# The Psychology of Nursing

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# The Psychology of Nursing

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To

THE STANFORD SCHOOL FOR NURSES

# FOREWORD

THE trained nurse, like *cloisonné*, is made up of many "precious things." Virtue upon virtue, gift upon gift, power upon power, the ideal nurse possesses. That she must be a psychologist has been recognized since the days of very early nursing.

In the old Hindu records we read that those caring for the sick should be "clever in reading the face and understanding the patient," which is only another way of saying that these nurses should know something of the science of the mind. Vincent de Paul gives in his teachings to the Sisters of Charity many hints of practical psychology.[1] In order to help the sisters in going about their nursing among the poor more intelligently, he taught them much concerning suitable methods of approach, the importance of understanding how their patients took things into the mind, the effect of manner, the place of suggestion in their work, the means of developing attention—all set forth in the simplest manner so that he might be understood by these nurses whose education was limited.

[1] Preserved in seventeenth century private edition, Bibl. Nat., Paris.

Florence Nightingale gives many illuminating reminders in her writings concerning attention to the mind's laws in nursing—for example:

"Nurses have to do with living bodies and no less living minds . . . for the life is not vegetable life, nor animal life but it is human life—with living, that is, conscious forces . . . ." Thus, here and there, throughout the history of nursing, we find recognition of the fact that good nursing includes knowledge of human behaviour, but not until the present day has psychology been given a definite place in the nursing curriculum.

The Committee on Education of The National League of Nursing Education now recommends that psychology be included in the first year of a nurse's study. The objects of the course as stated by this committee are:

"1. To attempt to state the fundamental principles underlying human conduct.

"2. To give the student practice in considering people's actions with impersonal understanding and sympathy.

"3. To develop certain principles of dealing wisely with patients and others in professional relations.

"4. To help the student toward self-mastery and good sense in the relationships of private life.

"5. To provide a basis for subsequent courses in psychiatry or ethics."[1]

At last, this important science is compelling a

[1] *Standard Curriculum for Schools of Nursing*, p. 38.

place that is definite in the instruction of nurses. The time will come, inevitably, when all training schools of high standing will include the subject in the course of study, and, as a result, the power of nursing will increase immeasurably. A large proportion of nurses' blunders occur because they do not possess a working knowledge of psychology. Psychology should not be considered as a subject which *may* be included in the nursing curriculum, but *as one which cannot be omitted.*

"If only they would send us nurses who know how to get at us!" This outburst, from a woman of the Mission district in San Francisco, is echoed by many of the poor and suffering we are trying so earnestly to help. Let us hope that the time is not far distant when public-health workers will be required to pass certain tests in psychology before they are given free rein in dealing with other people's needs and problems. The department of public-health nursing as well as every other branch of the profession, needs women who know psychology and how to apply it according to individual experience.

Nothing complex in psychological learning is needed. Fundamental practical conceptions—old as human nature—are what contribute to professional skill. It is not the purpose of this book to set forth the elements of psychology from A to Z, but, rather, to dwell upon the principles which are the direct concern of the nurse. We shall not get lost in a maze of technical expressions.

Nevertheless, let the student not forget that she is studying a science. Alertness of mind, constant analysis, fine discrimination are essential in acquiring a working basis of psychology. Such study should increase tenfold the nurse's interest and efficiency in every phase of her service.

Talks upon psychology, together with various exercises for study, given at The Stanford School for Nurses, form the nucleus of this book. For the convenience of the nurse, necessary definitions and references are quoted directly from recognized authorities upon psychology. If the busy life of the nurse will permit a more extended study, so much the better. The purpose of the book in hand is to aid the nurse in laying hold of certain elementary principles of psychology that will be of practical use to her every day of her life. Whatever is included, is given with the hope that the nurse will be helped in making the care of the sick "one of the fine arts."

I am indebted to E. P. Dutton & Company, to W. B. Saunders & Company, to Henry Holt & Company, and to Edward L. Thorndike for permission to use various standard explanations of psychological terms.

A. C. H.

San Francisco, California

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# The Psychology of Nursing

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## CHAPTER I

### THE PLACE OF PSYCHOLOGY IN NURSING

When a young woman enters training to become a nurse, her mind is centred, naturally, upon learning how to care for the sick. This skill cannot be acquired, obviously, without the knowledge of certain facts which she expects to learn from the study of various physical sciences. It is important that the young nurse should realize at once that another science is needed—the science of the mind. The average young woman does not think of psychology as having anything to do with *her*. Psychology, she thinks, is something for the consideration of teachers, or, perhaps, a study to dip into during college. Such a thing as considering the knowledge of this science as a part of her equipment, as part and parcel of her daily life, does not occur to her. A radical change of attitude toward this subject is necessary to the student entering a training school for nurses.

First of all, why does the nurse need psychology for herself?

Without the study of psychology, the nurse cannot carry out successfully the physical and mental re-education of herself which is a necessity if she learns to give the highest service in her profession. Difficult though this task of re-education may be, it is fascinating because it imbues the pupil nurse with a sense of infinite possibility. What may not be accomplished by a human being disciplined and trained to greatest demands? To become "a perfect instrument of service"—this is worth the struggle of breaking away from ideas and habits that are wrong.

Usually, the rigid physical examination an applicant undergoes before her acceptance into the training school brings sharply to her mind the fact that good health is essential to the nurse. She should know, as definitely, that health of the mind is to be considered as well as health of the body. She should be willing, not only to train her body to perfect control, to eliminate weaknesses, to achieve co-ordination, but to train her mind as well—to clear it of waste thought, perverted responses and blind purposes. Indeed, she must realize that the body cannot be developed to its full power without the accompanying discipline of the mind.

In order to bring about the re-education of body and mind, the nurse must be able to judge what making over is necessary for herself. In other

words, she needs to become an intelligent impersonal self-critic. All the willingness in the world to become an ideal nurse will not take the place of a practical knowledge of how to go about re-education. It is not enough to see one's own faults and deficiencies. They must be understood as well. Faults and deficiencies that are analyzed may be dealt with by direct attack. Capacities must be recognized before they may be developed properly into power.

A nurse who had tried very hard to succeed in public health work and failed, sought in her deep disappointment the reason for her failure.

"Why is it I have failed?" she cried. "Certainly I have given all I have."

Yes, she had done that—but she had not studied herself as a working power. She could not judge herself impersonally as a producing force. She could not see in herself the characteristics that were keeping her from success, much less could she eliminate them intelligently. Hers was what Stevenson terms "the itch of ill-advised activity." Like so many women, burning with the desire "to do something philanthropic," struggling "to find themselves" in some form of public work, she omitted the most important preparation.

Why cry, "Oh wad some power the giftie gie us" when, with study, we may develop the ability to see ourselves perhaps *more* intelligently than others see us? It cannot be maintained that, without fail, psychology will transform

the student into a scientific observer of herself or of others, but, as demonstrated, more than any other study, it will help to bring this about.

Merely telling a nurse that she should not do this or that is unsatisfactory in bringing about desirable results in development. She may listen attentively to the list of her shortcomings as her superior sees them—she may even reach the point where she feels no resentment at this recital—but this method of getting a nurse to realize her faults *will never take the place of self-criticism.* The active habit of taking stock of one's own self is the very heart of development. Obviously, to get this power of self-analysis, the nurse must first *understand* her mental life. Before she can set about to control her mind, she must comprehend the *means* of control. She must become acquainted with the reasons for mental facts. Once aware of herself, considering herself impersonally, understanding what is to be done, naturally she feels that she has a big task before her. To avoid discouragement at this point, she needs to comprehend the *possibilities* of controlled power. If she can picture vividly the scope of her re-educated self, this will be incentive enough. It is too often a fact that the nurse has no well-defined conception of how gloriously her everyday life would be altered by the process of re-education. If this be the case, although the nurse may understand thoroughly what needs to be done, it seems in-

variably too great a task. She slips easily into the habit of "glossing over" her faults. She looks about her and sees many other nurses with just as many faults as she herself frankly owns. Since she does not suffer particularly by comparison, she reasons, why not disregard the work of making herself over? To obviate this possible state she must have the vision to see the possible new self in what is truly another world. The possibilities, once grasped, cannot fail to kindle her desire, to strengthen her will.

How is psychology to help the nurse in this making over process?

Suppose she has never mastered bodily control. Much of the fatigue of nursing may be obviated by physical power, based upon the laws of co-ordination. The performance of nursing procedures is harmful to the nurse only if the body is not moving in harmony with the laws governing bodily control. In John Dewey's words:

"True spontaneity is not a birthright, but the last term, the consummated conquest of an art—the art of conscious control."

The knowledge of such co-ordination cannot be complete without a basis of certain psychological facts.

Suppose she has been in the habit of admitting that she "can't remember things five minutes"; or, that she is the sort of girl who has never been able to take things out of books and apply them in her daily life; or, that she has no idea of how

to form a habit, to develop by system any capacity she may have—through the study of psychology she may learn how to remedy these defects and weaknesses. If she has found study a burden, if she "dreads Materia Medica" and "loathes Chemistry," if getting lessons is a strain—this state, so disadvantageous to the student, can be changed. A new attitude toward study, making it pleasurable and easy, can be developed. The word "inhibit" may mean little to her in the beginning, but it will prove useful indeed in harness. She can learn how to do all her work, both physical and mental without that painful dragging effort—that pushing-a-cart-uphill feeling. Her existence will be illuminated by the practical truth that she can create her own world. "*Attention*"—let her ring out this command to herself and fix her mind upon what she wills. Immediately she will find a new inspiration in her work. Eventually she will become a master hand at living.

In all this, and more, as we shall find, the study of psychology will help the nurse.

And now, why does the nurse need psychology for her patient's sake?

Minus the revealing laws of the mind, the nurse cannot meet adequately the constantly varying problems she has in dealing with her patients. Without this science, she can never attain the most satisfactory professional relationships. The nurse is often confused by trying "to be professional," and, at the same time, sympathetic in her attitude

toward her patients. She can learn to be impersonal in her judgments of others and to show a fine sympathy, based upon intelligent analysis. Professional poise is not to be put on and off like "Sunday clothes." It is developed primarily from an understanding of psychological laws. By the use of rudimentary knowledge of human behaviour, the nurse may save her patients untold discomfort. In all the detail of her work the nurse may be helped by the use of psychology.

"I am going to sit up tomorrow," announces a wilful patient.

"Oh no, you are not—of course you will not be able to get up tomorrow," responds the nurse. She is complacently ignorant of any method of management except by "blocking" crudely the patient's desire. For the hysteria which follows, she does not hold herself at all responsible.

The nurse who uses her little stock of professional phrases indiscriminately—as if all words have the same meaning to all patients—is merely amused at the terror of the ignorant mountaineer when she tells him that he must have a lavage. It does not occur to her to explain to him in simple words, such as "washing out the stomach," so that he will understand. She traces no connection of his terror over what is going to happen to him and his effort to escape from the hospital. She gives no thought to choosing her language in accordance with her patient's power of perception.

The nurse who chats thoughtlessly while she is

giving her patient his bath, wonders why he is "all tired out."

The nurse "can't get" her patient to take his medicine. She does not realize that she is ignorant of the first principles of approach.

The patient is sulky. Does the nurse concern herself with the significance of the impressions responsible for such a state? Every day the patient has a fit of melancholy. Does the nurse feel any responsibility in warding it off?

The nurse gives her patient a drink. She does not know that the reason he drinks so little is because his head is thrown forward too far, the drinking cup held at the wrong angle. Execution —what does she know of it scientifically?

The patient is inattentive to certain instructions concerning a prescribed treatment. Does the nurse know how to help him to fix his attention adequately?

An endless list this—the list of blunders made by nurses ignorant of the fact that psychology has to do even with such details as giving a drink of water, listening to the patient's tales of woe, entering a room. So much has the science of the mind to do with the minutest care of the patient that the nurse might well call her note-book upon psychology "How to Make My Patient Comfortable."

At the outset, let the nurse get a definition of psychology that means something more than so many words to her.

What is psychology?

An acquaintance with the definitions by well-known authorities will help the nurse to formulate in her own mind a practical working definition.

"I wish psychology had another name," the probationer sighs. "It would be so much easier to start."

With the word psychology there is a struggle usually before its friendly acceptance in the mind. How much greater would be the general interest in the subject, if the facts of mental life were assembled under another name—an altogether alluring term, a short word with a nice sound of holding something for everyone? The mind has to "break" even the commonest psychological expressions before they are connected as they should be with everyday movement.

Call psychology anything you like, only choose a name that helps you in learning how to do your work, in living so that living counts. Many a college student with a grade of A in Elements of Psychology, Psychology of the Crowd, Criminal Psychology, and all other available courses in the science, wanders forth in life in the same old unintelligent way, his knowledge of no vital use because he has never learned how to apply it. On the other hand it is possible to study psychology and to make daily use of its principles without labelling them by their technical terms.

A dear little old nurse who was graduated before training schools had a well-established curriculum,

treasured a note-book that she kept during her practice. The title reads: "Human Antics" and the book contains a wealth of psychological suggestions in homely quaint phrasing. The first page reads:

"Don't tell my patient more than one thing at a time—his knack of taking in things is weaker than a healthy person's. Stand facing him when I speak to him—otherwise I add to the strain of listening . . . Even my little finger has to be taught to mind me in my work. . . . Just because my patient ohs and ahs over her orange dessert, I'll not keep on giving it to her until she stops oh-ing and ah-ing. . . . Mr. B. couldn't understand about the tube the doctor put into his side, until I showed him a picture and explained at the same time in short easy words. Unless patients are too weak, they take in ideas quickest by seeing. . . . I must learn to remember different details for each patient if I satisfy them. Nothing is too insignificant to remember. Mrs. C. demands attention to a list of things a yard long—mostly little things, such as pulling the shades just so, putting her husband's picture where she can see it without lifting her head, arranging her flowers in certain ways—the irises in the grey and orange bowl, the pansies in the old blue squatty one, the roses in the crystal jars. She says roses nauseate her when they begin to turn that dismal magenta, so I must get them out of the room before they fade. She always wants her

cap with ribbons on her head before the doctor comes. She is cross if she isn't ready for his call. She pretends it is something else, but I can tell. If she starts out cross in the morning she is never satisfied with her food all day long and eats hardly anything. So I always do my best to get that cap on in time. . . . Mr. J. is as stubborn as a mule, but I get around him by never saying outright that he can't do things. . . ."

This wide-awake observer of human behaviour did not know that her gleanings had any bearing upon psychological truths. She would have been appalled by the scientific facts to which her observations are related. So, let us repeat, make up another name for psychology if you like. If the word psychology does not find a cosy place in your mind, seek until you find a term that will be sociably at home with your stock of ideas.

One point never to be forgotten—no matter how the subject may be taught in the training school, the student must teach herself to a great extent. This power of teaching one's self, is one of the elementary essentials in acquiring useful knowledge of this science. In no other way can the nurse lay hold of working principles exactly adapted to her own use. She may have a good instructor to help her, or, she may have none at all. The main thing is to realize the need of psychology and to set to work to get it. Want it! Get it! Use it!

## Definition of Psychology

1. "Psychology is the Science of Mental Life, both of its phenomena and their conditions." (W. James.)

2. "Psychology, the science of mental facts or of the mind, deals with . . . the thoughts and feelings of men and of other animals, ideas, opinions, memories, hopes, fears, pleasures, pains, smells, tastes, and so on through the list of states of mind. . . . Human psychology deals with the thoughts and feelings of human beings and seeks to explain the facts of intellect, character, and personal life. The questions which the science of psychology tries to answer . . . centre about four leading topics:

(1) The nature of different thoughts and feelings.

(2) The purpose which they serve in life.

(3) The ways in which they are related to the action of the brain or nervous system.

(4) The laws which govern their behaviour and that of the bodily states and acts connected with them.

"*E.g.*, psychology should give information about:

(1) Just what attention is.

(2) In what way fear or pain is useful in the conduct of life.

(3) How softening of the brain produces idiocy or how fever produces mental confusion.

(4) Why thinking of one thing makes one think of a certain other thing, or why practice makes perfect.

Its task thus concerns the description of mental

states or processes, their function in nature, their relation to the nervous system and the general explanation of the part played by the mind in human life." (Edward L. Thorndike in *Elements of Psychology*

## Questions for Study

1. What sciences are necessary in the training-school curriculum?
2. Why does a nurse need a knowledge of psychology for herself?
3. What do you understand by the term re-education?
4. Give specific examples of how psychology may help the nurse in the making-over process.
5. How may the student know how to go about re-education?
6. Why does a nurse need psychology for her patient's sake?
7. Give examples from your own observation of nurses' blunders that might have been obviated by a working knowledge of psychology.
8. Give a definition of psychology which you hold in your mind as *your* definition.
9. What do you hope to learn from the study of psychology that will be of practical value to you?
10. Write ten questions which you consider helpful to a nurse in developing self-criticism.

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### Questions for Re-education

There is no quicker way for the nurse to develop the power of self-analysis than by asking herself searching questions and answering them squarely. As an aid to such development, suggestive questions for self-criticism and occasional notes will follow each chapter. It will help the nurse, if, in addition to the use of these questions, she will keep a note-book devoted to questions which she formulates herself. Answering the questions in writing for her own honest perusal will do wonders toward the nurse's re-education.

1. What faults do I admit that I possess? Am I big enough to make an honest list of these faults in black and white? Do these faults that I admit to myself correspond with the faults that my parents or my friends mention to me? What faults have I concerning which no one has ever spoken to me? Do I try to cover up my faults? What are my faults of omission?
2. Would I be a more helpful human being, a more desirable member of society without my faults?
3. Do I sincerely wish to get rid of my faults? Do I take pleasure in any of my faults? Do I coddle them?
4. Am I lazy about trying to eliminate my faults?
5. In what specific ways would my life be changed if I should get rid of my faults?
6. What undeveloped capacities do I possess?
7. How can I gain a better understanding of my undeveloped powers?

8. In what ways would my life be different if I should develop these capacities?

9. Have I ever tried to formulate a definite ideal of the kind of person I should like to be? Why will putting it very exactly into written words help me?

10. Do I understand my mental life? Do I understand my own behaviour?

## Types for Study in the Psychology of Nursing

Before pursuing the study of this book, the student is asked to become thoroughly familiar with these personality sketches of nurses and patients:

### Types of Nurses in Training

1. Mary Anderson—Home, Triple Ranch, Montana. High-School education. Accustomed to managing. Good executive ability, developed by helping her father "run the ranch." Practical. Careless of etiquette. Impulsive. Inclined to slight things she doesn't like to do. Fond of nature study. A wide knowledge of the out-of-doors. No well-defined ideas of how to study. Dictatorial. Believes in "saying what she thinks." Strong, well-trained physically from her active life upon the ranch. Intolerant of injustice, evasiveness, cowardice, untruth. Good-looking with a fine colour, a vivacious expressive face, but careless of her appearance, particularly of her hands and her hair.

2. Elizabeth McCaskell—Home, Grayville, Illinois. High School education. Very little experience of any kind—the result of her narrow, small-town life.

No travel. Imaginative, romantic, full of ideas culled from light novels. A dreamer, with desires for "bigger things." Nervous temperament. Timid in making practical applications. Physically and mentally undisciplined. Alert. Understands a situation quickly. Notices little things. Sympathetic. Pretty—somewhat of a Greuze type. Good taste in colours, but with little idea of what is good form in dress.

3. Ann Sherman—Home, Orange, New Jersey. One year of college at Smith. Brilliant student. Prominent in athletics. Painstakingly neat. Particular about detail. Inclined to be "fussy" about having things just so. Critical of others. Accustomed to working in organizations but unable to "get along" in committee work. Generous about helping others but eager to get the glory of it. Without much poise. Morbidly affected by the tragic aspects of life. Overserious. A high idea of "doing her duty to humanity." Slender, wiry type. Inclined to overdo. A nervous habit of frowning and using unnecessary facial muscles when she talks. Does not know how to dress in order to make the most of her good points physically. Refined face. Wrong posture of shoulders and hips.

4. Isabel Terry—Home, Parkerton, Kentucky. Graduate of a boarding-school. Rather indolent. Spasmodic in her attention to exercise. Plays tennis until she is exhausted, if she is interested. Self-centred. Unused to doing things for people, except when she "takes a notion" to someone. Afraid of authority. Secretive. Not always truthful. Tells stories well. Loves to enlarge upon fact to make an effect. Poor student. Deft—does everything well

with her hands that she attempts. Clever at embroidery and original designing. Attractive personality. Good manners. Graceful. Striking appearance. A bit inclined to pose. Knows how to make artistic effects with simple things. Healthy, but with little endurance.

5. Frances Tracy—Home, Hibbing, Minnesota. Education mostly in private schools and with tutors. Her father a man of wealth. Residence changed frequently. Considerable travel in South America, Mexico, and unusual places. Sensitive to impressions. A great reader. Not always sure of what she wants to do. Rather cynical. Inclined to be restless. Abrupt in her manner. Interested in varied types of people. Not fond of exertion. Accustomed to having things done for her. Rather unattractive face due to her expression mostly. Speaks Spanish, French, and Italian.

### Types of Patients

1. E. J. Andrews—A wealthy business man. President of a lumber corporation. No interest in anything besides his business. Unaccustomed to illness. No education for higher enjoyments. Nervous break-down and appendicitis. Authoritative. Impatient. Approaching middle age. Dreads getting old.

2. Mrs. Telford Worthington—A society woman. An *habitué* of the hospital. Nervous. In the hospital for observation, X-ray, etc. Hypercritical. Selfish. Inquisitive. Rather pretty in a superficial kind of way. Makes a hero of her physician. No idea of philanthropy except signing checks for this or

that popular charity. Wants to be entertained constantly. Few resources within herself. Does not recognize this lack.

3. Dr. Sanderson—A surgeon. Noted for cancer research. Wide experience. Foreign study. Much travel. Stricken with cancer. A young man to have accomplished so much. Melancholy temperament. Fond of nature study.

4. Pierre La Vaque—A patient for reconstructive surgery. Arm, leg, and face injured. Little knowledge of English. Knows little of hospitals except as places where people he has known have died. Brought up on a farm. Knows nothing of scientific farming.

5. Mrs. O'Brien—A patient in a free bed. Greatly worried about her three children at home. Her husband inclined to neglect visiting her after she has been in the hospital for some time. She has never been ill before in her life. Her leg injury will prevent her continuing the work of cleaning which she has always done to support her family. Knows nothing about knitting or doing anything with her hands except the hardest work.

## CHAPTER II

### CONSCIOUS FORCES

As the five probationers, Mary Anderson, Elizabeth McCaskell, Ann Sherman, Isabel Terry, and Frances Tracy go up the steps of the hospital on the day of their entrance to the training school, the "heart" or centre in each field of consciousness is the same—the sensation of taking in the new surroundings. All sensation of fatigue from the journey, notice of the rain, previous images of "what it would be like" vanish at the sight of the hospital. Around this new focus of sensation is a shading—think for a moment of the way you used to fringe mountains on your maps at school. This fringing differs in the consciousness of each probationer.[1] In Elizabeth McCaskell, around

[1] The following explanation of the "focal object" and "marginal object" is selected from Talks on Psychology by William James:

"We have thus fields of consciousness—that is the first general fact; and the second general fact is that the concrete fields are always complex. They contain sensations of our bodies and of the objects around us, memories of past experiences and thoughts of distant things, feelings of satisfaction and dissatisfaction, desires, and aversions, and other emotional conditions, together with determinations of the will, in every variety of permutation and combination. . . . In most of our concrete states of con-

the sensation of seeing for the first time the hospital where she expects such wonderful adventure, are the marginal emotions of shyness and awe. In Mary Anderson the fringing is a mixture of impulse and memory. So remote the huge building seems from her out-of-doors that she feels inclined to run down the steps instead of entering those formidable doors. A memory picture of her beloved ranch home flashes to mind and she is perilously near tears. In Ann Sherman, as she pauses at the door, there is the solemn feeling of "making a choice." There forms in her mind a well-defined intention to make good in the new life. In Isabel Terry's margin surprise and fear intermingle.

"I didn't think it would look like this!" she exclaims to Frances Tracy, the last to ascend.

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sciousness all these different classes of ingredients are found simultaneously present to some degree, though the relative proportion they bear to one another is very shifting. One state will seem to be composed of hardly anything but sensations, another of hardly anything but memories, etc. But around the sensation, if one consider carefully, there will always be some fringe of thought or will, and around the memory some margin or penumbra of emotion or sensation. . . . In most of our fields of consciousness there is a core of sensation that is very pronounced. . . . In the successive mutations of our fields of consciousness, the process by which one dissolves into another is often very gradual, and all sorts of inner re-arrangements of contents occur. Sometimes the focus remains but little changed, while the margin alters rapidly. Sometimes the focus alters and the margin stays. Sometimes focus and margin change places. Sometimes, again, abrupt alterations of the whole field occur."

"What *did* you think?'

"Oh, I don't know exactly—but not like this——"

Frances Tracy vouchsafes no answer. She is experiencing a feeling of great suspense. Is this the hospital she should have chosen? What is it like inside?

Suddenly, an hysterical shriek from an open window reaches them.

No longer are the five girls gazing at the general appearance of the building. Five pairs of eyes are centered upon the window and in each field of consciousness the marginal fringing is altered.

Bessie McCaskell pricks up her ears sympathetically, but notes in relief that the patient "doesn't sound as if she's hurt." Ann Sherman is all anxiety concerning the cause of the outcry. Already she feels the burden of responsibility. Is the poor soul receiving the proper attention? Mary Anderson puts her fingers in her ears to keep herself from "imagining things." Frances Tracy listens to the hysterical outbursts with a feeling of half-aversion. Does she, after all, want to take care of sick people? Isabel Terry apprehensively remarks that the patient will probably jump out the window.

Thus we might go on, dwelling upon the successive changes in these five "streams of consciousness"—noting the continual fluctuation and the significance of the alterations in focus and margin. It is apparent that such study includes considera-

tion of endless changes with complex differences in each individual. The far-reaching reasons for these different responses to the same stimuli are to be found in the history of each individual's experience, heredity, sex, age, together with the interwoven influences of temperament, mood, health, weather, purpose, and so on

The probationers recognize in their first appraising glances at one another that each girl differs from the others in countless little ways. Isabel Terry, for example, notes with complacency that not one of the other girls wears clothes so effective as her own, which cost half what Frances Tracy must have paid for her gaudy over-trimmed suit. Isabel longs to put the right kind of hat on Ann Sherman and to see how Bessie McCaskell would look in clothes that were intended for the street. What are the reasons for the differences in their clothes? Why is each turn of the head, each spoken word—everything—different? How much do the probationers think of the real meaning of their varied attitudes toward the new scene? To be sure they know that within them "some kind of consciousness is going on," but concerning its nature, its origin—what knowledge do they possess? Can they tell of what their fields of consciousness are made up? How their mental machines work? It is not unusual that these five young women have given but little thought to the significance of the inner life. There is but little, as a rule, in the general plan of a young girl's

education to awaken her to the need of any such consideration. She is made to realize before she leaves High School that she must know this and that rudimentary fact about her physical self in order to care for her body intelligently and to avoid sickness. Elementary physiology and hygiene are accepted as practical subjects to include in her education. How much does she learn concerning the working of her mind? What practical basis has she in the science of consciousness? Does she understand, as psychologists repeatedly point out, that the function of her mental life is to stimulate and to direct action, to guide her forces, to help her make use of herself?

If, before our young probationers open the door of the hospital, they could be made keenly aware of their forces—what a tremendous advantage this would be to them! If only they might realize what they are and what they may become by organized effort! This *awareness* of themselves plus active attention to development would be their greatest help in training. Together with this recognition of themselves as working forces, would come an illuminating readjustment of the way they regard those with whom they come in contact. Innumerable blunders would be avoided, stumbling-blocks removed, worries eliminated. What a step toward free advancement!

Let it be borne in mind then that what the young nurse needs most when she enters training is *awareness of her mind as a working force* together

with recognition of her undeveloped power and her wrong habits of behaviour. She would think an automobile manufacturer "mad as a hatter" if he did not know and understand the power of his factory; if, despite the demand for his cars, he kept most of his machinery idle; if he neglected to make right things in his working force which were crippling his output and causing him trouble. Let the nurse comprehend something of the power within her; let her realize the millions and millions of her brain cells not in use, the faults and weaknesses that are holding her back. The world needs her dormant power. Never in the history of nursing has there been such a demand for highly trained women. We all see that some nurses are better than others. There is a reason why the surgeon selects a certain nurse to assist at a critical operation. There is a reason why some graduate nurses are always busy at the kind of work they want to do, and others are always complaining because they have to take "anything that comes along." The difference in the professional ability of nurses lies primarily in the amount of power allowed to remain dormant.

Let each nurse ask herself, "What am I? Why do I exist? 'Sensations, memories, thoughts, feelings, determinations of the will' which make up my field of consciousness—what is the practical meaning of these things? To what end is the training of my conscious forces directed? Do my forces concern me alone?"

A full consideration of such questions cannot fail to make stable the nurse's ideas concerning the aim of her training.

To any one keeping in touch with modern ideas as set forth by many prominent writers, "getting an education" presents a fivefold aspect. This, as summarized by George Drayton Strayer, includes:

1. The training of the physical self.
2. The education of the intellect.
3. The development of the moral-social ideals.
4. The special training for a vocation.
5. The not-to-be-forgotten "training for leisure."[1]

It is plain from such references that "getting an education" means something more nowadays than merely learning how to earn a living or to develop one's particular abilities without regard to the individual's usefulness in the world. The girl who goes to college, intent upon developing her gifts in order that she may become a more attractive member of society and win more hand-clapping, soon learns that she is "on the wrong tack." Likewise the business woman who does not set her mind beyond acquiring a certain skill that will bring a return in money. We hear a great deal about "social efficiency." Indeed, so much is the expression used that it makes less

[1] G. D. Strayer, *The Teaching Process*, Chapter I.

impression than it should make in order to prod people to the effort of getting an education in the highest sense. Nevertheless, the constant setting forth of an ideal has its effect. Our Boy-Scout movement has social helpfulness as its underlying principle of action. During the war the meaning of "social efficiency" was brought home to everyone who wanted to do something to help his country. The national call for help led to general taking stock of individual abilities. The question we had to answer was not what we wanted to do, but what we could do to be of service. The various bureaus of personnel, passing upon the usefulness of would-be helpers laid bare a very general lack of well-rounded education.

"My education has been all wrong." This was the assertion of many patriotic men and women educated without attention to their power of service. The war has helped to put into activity an aim which has been too long bandied about as so many words. However prominently to the fore though the recognized aim of education may be at the present time, we are still very far, either from teaching it as we should in our schools so that it will naturally be put into practical use, or, from accepting it without reservation as individuals. It is one thing to recognize an aim—another to try to achieve it.

It is obvious that nursing calls particularly for acceptance of the higher educational aim. Indeed, it is scarcely necessary to state that any young

woman who is not wholly in sympathy with the ideal of fitting herself for a place of service in the world, should abandon the idea of becoming a nurse. Perhaps she may be able to secure a position demanding nothing more soul-inspiring than stamping things off in a room by herself—or can you suggest a place where she would do even less harm? It is to be noted that a wrong aim acts as a boomerang. The commercially minded nurse can never get from the profession the finer satisfactions in store for the nurse who lives by the higher ideal of service.

While we term as modern the aim of social efficiency in general education, this ideal was fostered very early in nursing. From A.D. 60, the time of Phebe, the first parish worker and district nurse, we find in the history of nursing, examples of women whose desire in learning how to do their work was quite in accord with the present-day idea of education. At Kaiserswerth the nurses under the Fleidner training took thought of the places for which they were preparing. Their "Questions of Self-Examination" included many which concerned their measure of helpfulness. Caring for the sick calls naturally for a consideration of social sympathy made useful and practical through training.

As soon as the nurse has a well-defined idea of education she is vitally concerned with the direction of her conscious forces. She finds out all that there is to find out about her working power.

What she is able to make of herself depends upon this understanding of her conscious forces, plus the necessary training.

### Definitions

"Education, in short, cannot be better described than by calling it the organization of acquired habits of conduct and tendencies to behaviour." (William James, *Talks on Psychology*, p. 29.)

"Education should be considered, not as a moulding of perfectly plastic substances, nor as a filling of empty minds, nor as a creation of powers; but rather as the provision of opportunity for healthy bodily and mental life, of stimuli to call forth desirable activities in thought, feeling, and movement, and of means for their wise direction, for the elimination of their failures and futilities, and for the selection of their useful forms." (E. L. Thorndike, *The Principles of Teaching*, p. 39.)

### Questions for Study

1. How do conscious forces operate?
2. What do we mean when we say that we are unconscious of things going on about us during waking hours?
3. Describe the probable "margin of the conscious field" in each of our five probationers when rising for the first time to a graduate nurse.
4. What do you understand by the term "social sympathy"?
5. Which one of our five patients do we find hardest to entertain during convalescence? Why?

6. What is your idea of "getting an education"? How did you get this idea? What has caused alterations of the idea you had ten years ago?

7. What did "going to school" mean to you? Why does entering the training school mean something different to you?

8. In what way does a wrong aim in education or work act as a boomerang?

9. What is your rating in the "average adult" tests? (See L. M. Terman, *The Measurement of Intelligence*, Chapter 19.)

10. Why is it particularly important to consider the probable margin of a patient's conscious field when he enters the hospital? Designate the probable margin in each of our five patients when brought into the hospital.

11. In what ways has the education of each of our five probationers been deficient?

12. Which probationer will be able to take the most exact inventory of her forces? Which one will find it the most difficult to admit her faults?

NOTE—It is suggested that the instructor in charge should conduct the tests for the average and the superior adult as given in *The Measurement of Intelligence* by Lewis M. Terman. The tests are simple and easily made. Allowance should be made for confusion on the part of the students. Helpful tests are also to be found in Edward L. Thorndike's article, "Intelligence and its Uses."

Every nurse knows the importance of the urine test, the blood count, and so on when the patient

enters the hospital. She knows why great care must be taken with these things. Any nurse, if asked the reason for their importance, would say, naturally, "Why, these are the things the physicians depend upon for diagnosis. Without them they couldn't go ahead intelligently."

Is it not obvious that we need intelligence tests in order to take correct stock of ourselves? It is well worth while to make such tests, eliminating as far as possible everything that leads to inaccuracy. Let us get all the help of this nature that we can, in order to avoid stumbling along in the dark.

### References

James, William. *Psychology*, Chapter 11.

Terman, Lewis M. *The Measurement of Intelligence*, Chapter 19.

Thorndike, Edward L. "Intelligence and its Uses," Harper's Magazine, January, 1920.

### Questions for Re-education

1. In measuring my intelligence, how can I account for my deficiencies?

2. Have I developed the power of measuring other people impersonally? How much am I affected in this judgment by my likes and dislikes?

3. In considering any talent I possess, have I made use of it to win hand-clappings or to give pleasure and help to other people?

4. What have I ever done which shows development of my moral-social self?

5. What training have I had for leisure? How may I train myself for leisure?

6. What things do I enjoy? Do my present enjoyments signify refinement?

7. What does it mean to be vulgar? Do I understand it in the sense that Ruskin describes it?[1]

8. What do I do that is vulgar in the least degree?

9. Is my education planned to include the fivefold consideration?

10. Am I in complete sympathy with the modern idea of education?

11. Why do I wish to become a nurse? Does the reason I give to other people correspond to the one I state to myself?

12. What is the advantage in learning how to study people as types? Is there any danger of blunting my sympathies in this way?

[1] "The essence of all vulgarity lies in the want of sensation. Simple and innocent vulgarity is merely an untrained and undeveloped bluntness of body and mind; but in true inbred vulgarity, there is a deathful callousness. . . . It is in the blunt hand and the dead heart, in the diseased habit, in the hardened conscience that men become vulgar; *they are forever vulgar precisely in proportion as they are incapable of sympathy—of quick understanding* —of all that, in deep insistence on the common but most accurate term, may be called the 'tact,' or touch-faculty, of body and soul; that tact which the Mimosa has in trees, which the pure woman has above all creatures; fineness and fullness of sensation, beyond reason; the guide and sanctifier of reason itself."—Ruskin, John, *Sesame and Lilies.*

## CHAPTER III

### HUMAN ADJUSTMENT

It is important at the outset that the nurse should consider the stimuli that are under her direct control. She should never lose sight of the fact that her tone of voice, her words, her gestures, her facial expression, her carriage, are stimuli of consequence in her world of work. Without being self-conscious, she needs to think of the impressions she makes. What is the effect of her habitual "Good morning"? Does it brighten, does it sing of vitality and interest in life,—or is it a dull, flat utterance adding gloom where gloom may be? Too much stress cannot be laid upon the effect of the nurse's personality. Her "nursing touch" is a stimulus with unlimited possibilities for desired reactions on the part of the patient. As the nurse studies her patient, noticing closely his responses to the smallest stimuli, she grows to understand her responsibility in directing properly the stimuli under her direct control. Her careful regulation of ventilation, sound, food—of all nursing procedure—is vital to his interests. Good nursing technic calls for intelligently directed stimuli, a

calculation of desired reactions. Vagueness has no place in the care of the sick. The deep interest of nursing lies in seeing the result of proper stimuli. It is fascinating to take over a neglected flower garden, to give it scientific care and to watch the drooping leaves lift, the new buds sprout, the new life quiver through the plant life. How much deeper the thrill that comes from observing human life, responding to care, nursed back to health!

We have William James to thank for the maxim, "No reception without reaction, no impression without correlative expression" a truth the nurse should remember as she remembers "Cleanliness is next to godliness." Such a working basis saves the nurse from getting careless about little things, or thinking that the patient "doesn't notice." Everything matters. Let the nurse not discount the smallest stimuli. The nurse's training makes for discrimination between helpful and harmful stimuli both from the standpoint of the nurse and the patient.

The study of stimuli which the nurse can only control indirectly leads her to a broader view of her efforts and an acceptance of added responsibility in the general atmosphere of the training school. More than this she learns something of outside influences. This consideration increases her initiative and accentuates definiteness of behaviour.

"In Buenos Aires the clothes I wore, the food I ate, the things I did to amuse myself were not

the same at all as in Hibbing. The two places are so different, I had to adjust myself to different ways," Frances Tracy says, in speaking of her travels. "A person is naturally affected by his environment."

"Was Buenos Aires just the same after your visit?"

Frances gasps at our question.

"Change Buenos Aires? Frances Tracy change Buenos Aires? It's too big——"

"Was nothing—nothing at all altered by your stay there?"

"Oh, little things, of course. I induced some of the mothers on our street not to give their babies black coffee to drink. I taught our Spanish servants a little English—before I left they were trying to read the English newspapers. Maria cut a pattern from my boudoir cap and all the maids around began wearing caps like it. Oh yes, there were many such little things. One can't live in a place without making an impression of some sort, I suppose."

This is her way of sketching what psychologists outline thus:

"People . . . considered as organisms, adjusting to changing environment, natural, and social, by acting upon the environment. Behaviour is such adjustment."[1]

The sum total of a human being's behaviour

[1] *Outline for Elements of Psychology, Standard Curriculum for Schools of Nursing*, p. 128.

includes, not only his purely personal adjustments, but his part in community and national adjustments as well. The tremendousness of such consideration! If we follow ourselves in retrospect through a single day we are staggered by the unending changes we have confronted, the countless adjustments we have made to "environment, natural and social."

In acting upon our environment, we leave, inevitably, a mark—a fact which compels us to more thoughtful adjustments. To consider a few marks which are significant of various types of behaviour:

A picturesque country nook is left by pleasure-seekers littered with papers and remains of the feast. A lighted cigar is thrown near the dry underbrush—a menace to the forest.

A man who has a difficult time getting his automobile over a muddy place upon an isolated road, takes the time to play road-mender and throws on a "filler" of light brush and straw for the comfort of the next traveller who comes along.

The marks of the average tenant make the house owner philosophize:

"It's natural, I suppose, that a tenant shouldn't care about keeping the flowers and shrubs in order—they are not *his* flowers and shrubs. But what of the dirt and trash he leaves behind? Why should the tenant who doesn't respect other people's property be the rule and not the exception?"

The bees put the careless tenant to shame. When they swarm out of their hive they leave

everything spick and span, for the bees who remain. If there are cracks which let in too much moisture, the bees seal them up. Mould, stray pieces of refuse, all these are painstakingly removed, or, if this is impossible, sealed air-tight so that they can do no harm. In general the hive is in better condition than when they moved in.

Along the roadside where no flowers grow, a tourist scatters a package of flower seed. Over the later burst of bloom which renews itself every spring, a succession of travellers cry out in delight.

So they go—the endless marks tell the history of adjustments. Wherever we go—in trains and street cars, in other people's houses, in churches, into the country—what marks do we leave? The gipsy patrin, placed at the roadway, a guide, a help to those of Romany who follow, spells a suggestion for us all.

In the study of adjustment to environment, the nurse has, first of all, her own room to think about. What personality, what behaviour is reflected there? What pictures does she select? What books are on her table? Does the room radiate cleanliness? Is there any evidence that she studies effects of colour? How many scratches and spots betray her vulgarity or her carelessness? The patients' rooms under her care reflect likewise, the nurse's personality. In her hospital work, the nurse has need to show thought of proper adjustment by nice care of equipment. The number of damaged hot-water bottles, hypodermic syringes,

and other utility-room articles, returned weekly to the supply for room exchange, testify to the lack of such thought upon the part of many nurses. In private practice, the nurse all too often leaves behind her a long list of damaged household articles.

We all know the type of nurse who is always having "accidents." What are the majority of her accidents but the result of improper adjustment to her environment? Why does the Florence flask slip out of the nurse's fingers? Because her kinæsthetic sense is untrained.

"I didn't know that it was so heavy," she says, betraying the fact that her muscles are unable to make a re-adjustment quickly enough to the unexpected weight of the flask.

Why does the stretcher scrape against the bed and jar the patient?

"I thought there was more room," the nurse states by way of excuse. Obviously, her eyes are not trained to calculate distances. Why does the hypodermic needle become an instrument of torture in her hands? She bends the needle because her calculation of resistance is not developed. One might make an endless enumeration of reasons for disastrous or unsatisfactory adjustments. The point is clear. No amount of goodwill, of anxiety to make perfect adjustments will ever take the place of systematic, careful training that will make such adjustments possible. How can a nurse expect to rub her patient's back satisfactorily if her fingers are stiff, utterly without deftness and skill

in massage movements? How can she be sure of doing the right thing in an emergency unless she has schooled herself to take in detail quickly and accurately? The body must be in truth "a perfect instrument of service" if we would avoid accidents and discomfort. Even such things as breathing, eating, walking, and so on—things to which we ordinarily give but little attention—play no small part in our general adjustment. One person can upset a whole classroom in "getting settled." The efforts of many people to make themselves comfortable are ludicrous proofs that study of the simplest kinds of adjustment is lacking.

The patient who disliked having his bath "because the nurse puffed so," awakened her to the necessity of learning how to breathe properly. Unfortunately, the nurse is not always made aware of the effect of her physical action. She goes out of the room and leaves the door creak-creak-creaking. She is not there to see the patient wince. She sits reading while her patient is trying to rest. She turns each leaf of her book with a rustle that keeps the patient on edge. With his eyes closed he waits tensely for the next rustle. Or, she leans against the bed when she has something to say to the patient. She is unaware that the patient is saying inwardly,

"This is *my* bed—this is *my* bed."

Not to offend by the smallest physical act in the performance of nursing procedures, should be the nurse's constant concern.

The problem of adjusting the human organism to the social environment, involves the many-sided study of "how to get on" with people, of how to make a general success of living. It is true that some people have the "knack" of getting on with people, but others, less harmonious by nature, can acquire the ability. It is our fascinating privilege to study human types, to learn suitable methods of approach, to lift coming in contact with people to a fine art. To be sure, it is harder for some people than for others to grasp the principles of dovetailing in human relationship, but there is no reason for any one to give up with the feeling that such principles cannot be acquired.

Many middle-aged men and women learned during the war for the first time how to get on with people. Not the least of the difficulties which confronted the various chairmen of war-work committees, was the needless friction among workers, caused, not from lack of desire to work—for workers were patriotic in their sincere wish to help—but because they did not know how to work as one of a unit. Their behaviour showed no training for social adjustments.

No one needs more than the nurse the good sense to see that all people cannot be treated alike. The moment the nurse begins to regard her patients just as patients, unmindful of the different human appeals, using the same method of approach with them all, she fails in her profession.

If any part of the nurse's education is neglected, she will be confronted by situations she cannot meet satisfactorily. Her action upon her environment will cause complications. She needs then to keep in mind the five-fold aspect of education, which, let us recall, includes: (a) physical adjustments, for which her body must be trained to perfect co-ordination; (b) mental adjustments, for which her mind must be broadly educated—the more she knows about things other than nursing, the better; (c) social adjustments, involving training for action, little and big—learning how to speak a greeting, how to ask for a yard of ribbon, how to approach a human being in distress, how to work helpfully with everyone; (d) vocational adjustments, for which she becomes specially trained as a nurse; (e) adjustments for leisure, which include learning how to enjoy things worth while.

The aim of education, in short, may be said to help us to make perfect adjustments.

### Definitions

"*Stimulus* is used widely for any event which influences a person—for a word spoken to him, a look, a sentence which he reads, the air he breathes, etc. The term *response* is used for any reaction made by him—a new thought, a feeling of interest, a bodily act, any mental or bodily condition resulting from the stimulus." (E. L. Thorndike, *Principles of Teaching*, p. 8.)

"In general the term *Situation* is used for any total set of circumstances in the outside world and in one's body by which the mind is influenced; *Stimulus* is used for any particular part of a situation; *Reaction* and *Response* are used for the act, and sometimes for the mental state, that occurs as a result of the stimulus." (E. L. THORNDIKE, *Elements of Psychology*, p. 17.)

". . . *Stimuli* cannot come to nothing. . . . Every stimulus has its result somehow and somewhere. The function of mental life we saw was to influence our movements—to cause what happened to us to result in actions that preserved our lives and happiness. The nervous system we now see to be a transformer of stimuli coming in, which are due to our surroundings, into stimuli going out which cause our actions, or in modifications of the nervous system itself." (E. L. THORNDIKE, *Elements of Psychology*, p. 163.)

"*Inhibitory Action*—That action in the nervous system discharges eventually into the muscles does not mean that it necessarily arouses movement. . . . Stimulation may regulate or decrease or check movement as well as initiate it. What we do *not do* as well as what we do is often a result of stimulation. Every nervous impulse tends to work itself out in action, but action means restraint, the opposition of one contraction to others, not doing, as well as mere movement. . . . In the mental world as well, we may suppose that the action of the nervous system may be to check as well as to arouse a sensation or idea. Nervous action may make one *not* think of a certain thing, *not* feel a certain emotion.

"When the result of nervous action is thus apparently negative—when it checks or restrains or lessens—the state of affairs is called *Inhibition* and the stimulus is said to inhibit the checked process. . . . We die when the vagus nerve to the heart is cut, not because the heart stops beating, but because it beats too fast; *i.e.*, over-acts. We are men and not brutes because the neurones concerned in the ideational and moral life keep in subjection and counteract the direct impulses to action of the neurones concerned in the instincts of greed, lust, cruelty, and hatred. We reason and do not merely day-dream, because we can check foolish irrelevant fancies—can inhibit all ideas that do not lead on to the desired goal." (E. L. THORNDIKE, *Elements of Psychology*, p. 164.)

"*The Law of Least Resistance*—When any neurone acts, *i.e.*, when it is stimulated and transmits, it will transmit the stimulus along the line of least resistance, or in other words along the line of strongest connection . . . the easiest path."

"*The Law of Inborn Connections*—The first law that decides what neurones any given neurone will arouse to action—what the line of least resistance or strongest connection will be—is then that, other things being equal, any neurone group will discharge into the neurone group with which it is by the inner growth of the nervous system connected."

"*The Law of Acquired Connections*—Any conduction of a stimulus from nerve cell to nerve cell tends increasingly to take the direction it has taken unless the result is discomfort." (E. L. THORNDIKE, *Elements of Psychology*, p. 165.)

## Questions for Study

1. What is the value of consciousness?
2. What is the meaning of stimuli? Response?
3. Give examples of stimuli which are not felt.
4. What types of behaviour do not require consciousness for their execution?
5. Explain the law of least resistance; the law of inborn connections; the law of acquired connections. Give examples drawn from your study of patients.
6. When in your experience did the inhibition of a wrong idea save you from regret?
7. What is meant by adjustment?
8. Write a description of Isabel Terry's room. Indicate the little touches that show what kind of adjustments she makes habitually.
9. Give an example of a mark indicating a low standard of behaviour. An example indicating a high standard.
10. Give an example of an accident you have witnessed that might have been obviated if a particular sense had been more highly trained.
11. What does getting on with people signify concerning adjustment to the social environment?
12. What are the characteristics of societies or groups of workers accomplishing the best work?
13. Give an example of an unsatisfactory adjustment resulting from an imperfect vocational training.
14. Sketch a situation involving embarrassment or ennui resulting from lack of training for higher enjoyment.
15. Think of someone you know who occupies a position of authority with harmonious results. What characterizes this individual's social relationships?

16. Play being a Sherlock Holmes and from some particular marks you see, trace a probable story of an unknown person's action.

James, William. *Psychology, Briefer Course*, Chapter 12.

### Questions for Re-education

1. What marks have I left in various places of which I have reason to be ashamed?
2. Have I ever left a mark which would beautify or improve an environment?
3. What physical adjustments do I make unsatisfactorily? What special training do I need physically?
4. How do I behave when I enter a roomful of people? How can I improve my adjustment in this instance?
5. Do I enter a patient's room satisfactorily?
6. What is my special problem of adjustment when I receive a new patient?
7. What does my room tell of my personality?
8. How much do I know about working with other people? Do I know how to be "one of a unit"?
9. What is the most awkward position I was ever in? What was the reason for it?
10. What influence has my habitual facial expression upon my adjustment in greeting a patient?

# CHAPTER IV

## INSTINCTS

"I NEVER know what to expect of people," Bessie McCaskell cries in despair. "How is one ever to learn?"

The number of different types encountered in a single day of the nurse's experience is enough to bewilder the nurse. It is difficult to become accustomed to so many moods, to such a variety of human action. To understand people, even a little, requires careful study. It is possible, however, to learn something of what to expect. A few psychological facts may be very illuminating in helping us to determine the reasons for differences in conduct, in preparing us for probable reactions.

First of all, the nurse will study the so-called mechanical modes of behaviour, *i.e.*,

1. Reflex action,
2. Instinctive action,
3. Habitual action.

After a careful study of the nervous system, as explained in the references given at the end of the chapter, the nurse will need nothing further to help her in recognizing simple reflex behaviour,

such as sneezing, coughing, and so on. Let us proceed then to a consideration of instinctive behaviour as noted particularly in patients.

Of all the instincts which the nurse sees manifested, she notices the *retractive* most. The naturally strong instincts of self-protection are intensified when illness weakens confidence in one's power to take care of one's self. Is there one of our five patients who does not feel *fear* in some degree upon entering the hospital? The ignorance of Pierre La Vaque concerning what is to befall him, increases his fear of the place he knows as "a house to die in." He makes no attempt to mask his fear. It is evident in his trembling hand, his wide, questioning eyes, his broken questionings. E. J. Andrews calls himself "extra nervous." He would not think of labelling this state indicative of fear. Mrs. Telford Worthington's fear is evident from the endless string of questions she asks to make sure that "everything is going all right." Her past sojourns at the hospital make her think of many things that *might* happen to bring discomfort and to stand in the way of her ultimate recovery. Dr. Sanderson's fear of the fatality of his disease shows itself in his deep melancholy. Mrs. O'Brien, quivering with fear lest she be "laid up for life," and kept from helping to support her family, cries hysterically. So it is—the majority of patients feel fear in varying degrees when they "have to be taken to the hospital" or even when they must remain confined to their rooms at home. The nurse

should be quick to note the manifestations of this instinct. It is often wiser not to speak directly to the patient of his fears, but, rather, to give him such reassurance that fear vanishes, or, at least fades into the background. Perhaps more than at other times, the nurse talks pleasantly and quietly about making him comfortable. He gets the soothing sense of being taken care of. The feeling of being in capable hands does much to ward off fear. The patient must have confidence in those about him.

The sick often become very much like little children in being afraid of the dark or of being left alone. They are afraid of what might happen when no one else is there. Ordinary noises take on at night a frightful sound. Childish these fears may be, but the wise nurse knows that the patient cannot be disciplined for them. She gives the patient reassurance that someone is always near at hand watching over him. She speaks the word of cheer at the needed moment. Many a patient summons the nurse in the night, not because he really wants what he asks for, but because he wants to hear a human voice. The night nurse needs particularly to take into consideration the instinct of fear, as manifested in little ways.

The strangeness of the hospital, its unexplained system, the unfamiliar appliances, tend to engender fear, particularly in patients with no previous hospital experience. Simple explanations or remarks preparing the patient for nursing proce-

dures experienced for the first time, should never be omitted by the nurse. The nurse herself becomes so accustomed to the hospital and sick-room life, which is her everyday existence, that she is prone to forget that the patient gets a very different impression. She may add to his fear thoughtlessly, instead of diminishing it. She should not fail to eliminate, whenever possible with safety, devices of restraint which tend to increase the patient's feeling of helplessness, since this tends to arouse fear. When a patient takes an anæsthetic, his feeling of powerlessness, his speculation on what is going to happen to him, fills him with terror. Restraint in such instances, applied before it is necessary, adds to this terror. . . . Simple instruments look very formidable indeed to patients if they have no idea of what is going to be done with them.

Back of all the lesser fears is the big fear—the fear of death. Unmentioned, as a rule—the thought of facing the unknown which persists in the patient's mind. Some patients try to overcome this fear by religious devotion, others by philosophical reflection. Not a few cover it by the nervous, flippant jest.

Many of the attempted flights from the hospital are the result of fear. Timidity at the new surroundings, if "blocked" becomes terror. Fear turns to depair. Hospital suicides, particularly of foreigners, are often explainable in this way.

Another of the self-protective instincts, *the re-*

*pulsive*, shows itself very often in the sick. When a patient thrusts away an appliance, mere dread of it may prompt the action. He may understand its use and therefore not distrust it, but his dislike of the application causes him to fight against it. In administering electric and other treatments, the nurse should be on the lookout lest the repulsive instinct express itself suddenly. The patient who "makes a fuss" over a treatment, lapses finally into disgust when he realizes that he has to go through the ordeal. The nurse, knowing this effect of the blocked, repulsive instinct, works to eliminate the feeling of disgust. There is always a method of getting the patient to take another attitude. Usually, the patient feels more kindly toward the hated treatment each time he undergoes it. Familiarity overcomes disgust. The absurdity of fighting against himself gradually dawns upon him. The nurse can always help to make him see this absurdity. She can always touch his imagination by picturing brightly the benefits to be derived from the treatment. Extended reasoning with the patient is seldom possible. The nurse should not expect always to get the patient's co-operation by appealing to his common sense; often she must secure it in some other way. . . . If, in dealing with new patients or undertaking a treatment for the first time, the nurse is on guard for the expression of the repulsive instinct, she may avert much disaster to equipment and save the patient from pos-

sible injury. Sick children and semi-delirious patients, governed by the repulsive instinct will often push the nurse away when she is trying to administer to them, or they will throw articles off the table or tray. Children sometimes try to hide under the bed-covering—pushing and kicking away everyone who tries to "make them take their medicine." Any one accustomed to handling children knows that such outbursts are only made worse by physical restraint. This should be the last method of control to be used.

The instinct of *self-assertion* is manifested in the great egoism of the sick. The instinct to be the centre of interest, to command all possible attention is noticeable in a large number of patients. Such patients may be irritating to a degree that tries all the self-control of those about them. Self-assertive patients may be considerate in varying degrees of those who attend them, but their needs are the supreme consideration about which everything else must pivot. They feel neglected from very slight causes. Some of the characteristics of the self-assertive instinct—pride, vanity, arrogance—are shown by trifles such as the "dressing up" of Mrs. Worthington for her physician. She is annoyed if her pride in her gorgeous beribboned dressing-gown, her carefully arranged lace pillows, is not respected. She craves a compliment, when, ready and expectant, she awaits his footfall. . . . The general desire for approbation should not be forgotten by the

nurse. When a patient bravely takes his medicine or does a bit in helping himself, the word of praise means a great deal. The graceful ability to pay deserved compliments serves the nurse as well in the sick-room as the drawing-room. While the nurse will steer clear of flattery, she will not lose the opportunity to give honest praise. The use of praise in working with children, the feeble-minded, the insane, is well known.

The domineering attitude of many patients is to be understood as the self-assertive expression, springing from anxiety over self-protection. Naturally, the poverty-stricken, the unfortunate, are not the ones who show this instinct most. Through long thwarting of self-assertion they are often humiliated to the extent that they feel they scarcely have the right to live. This type of patient frequently shows an apologetic attitude when expressing his needs. The nurse who understands the effect of the sad, perhaps sordid history of the patient's failure in life, will be very gentle with him. She will save him the embarrassment of asking for service by attending his needs betimes. If she can restore his self-respect together with his health, this is for her an added triumph of service. . . . *Pugnacity*, when interpreted as "an unwillingness to be beaten in any kind of difficulty"[1] may serve the patient well, particularly in moments of discouragement. Sometimes it is necessary to rouse this instinct in order to

[1] W. James, *Talks on Psychology*, p. 54.

get a patient to help himself recover. It is particularly useful in helping patients who have become cripples to adjust themselves to living in a different way. The combative instinct in its less desirable aspect is not absent from the sick-room. Some people are "born fighters" and fight everything and everybody to the last gasp. Happily, this type of patient is the exception. When encountered, the combative instinct should be dealt with by judicious methods of approach. The nurse is always careful not to wave the red flag of direct opposition. She avoids antagonism by "getting around" such patients. She learns sweet strategy. Occasionally, the combative instinct shows itself suddenly and transiently in patients who are ordinarily very gentle. Resentment over fancied mistreatment on the part of the physician, the nurse, or any one within the radius of the sick-room, may cause an amazing flare. Combativeness is aroused by the attack of disease itself. Patients often fight against "giving up and going to bed." They do not want to have the doctor. They are stubborn in admitting that they are ill—too ill to help themselves. They do not want to give in to the onslaught that challenges their strength. In sharp contrast are such patients to those who fancy themselves very ill at the slightest indisposition and show no inclination to stay on their feet. . . . Having to make a change of surroundings will sometimes rouse the instinct of combativeness. Even the necessity of accepting

another chair in place of the accustomed rocker may upset an older patient to the extent of a "tantrum."

Fighting for an idea is the beginning of many a disturbance in wards and communities where the nurse deals with groups. The nurse will be quick to divert an argument when a patient waxes too combative over his point of view. Modification of this phase of combativeness may be turned to good purpose in establishing ideals in social-service work. In certain surroundings, new ideas can never flourish unless those who accept them are willing to fight for them "with might and main."

The secretion of valuables by patients in their rooms against hospital rules is an expression of the self-assertive instinct, sometimes combining with *acquisitiveness*, which should be dealt with persuasively.

Perhaps the adaptive instinct most noticeable in sickness, particularly in the hospital, is *inquisitiveness*. If a patient is not too sick, he has a great many questions to ask about himself and his new world. Sometimes these questions remain unvoiced, but it is certain that the attitude of inquisitiveness exists. A patient may try to find out things for himself, or, he may wait for things to be explained in the natural course of events. Frequently the nurse is asked to describe things which the patient cannot see for himself about the hospital. Curiosity is a normal feeling. It is a good manifestation

usually, when the patient is not too ill to ask questions. In the extremity of disease, the patient neither knows nor cares what is going on about him. After a severe illness, it is always cheering when the patient begins to ask questions about little family details, to show an interest in the hospital or the sick-room itself, to inquire perhaps concerning the progress of community or national affairs. The nurse will know the value of a pleasant bit of news before the patient asks for it. She will be sensitive to the mute, inquiring glances of frightened patients who long to ask the meaning of this or that. It is not necessary to speak the same language as the patient in order to reassure him that all is well. . . . The nurse will be sympathetic, but discreet in answering questions. Of course, there are many inquiries she may not answer for the patient's own good and for professional reasons. Here comes the test of her ingenuity. It is undesirable to offend the patient by a direct refusal to answer him. . . . A rule not to be disregarded is that the nurse should not talk to one patient about another. There are times, as in the case of Mrs. Telford Worthington's persistent questioning, "What is the matter with the patient in the next room?" "What are your other patients like?" and so on, when the nurse is sorely tried. She may always parry a question in turn, such as, "You wouldn't like me to discuss *you* with other patients would you?" This turn-about questioning, smilingly done, is one of the

most desirable ways of making an over-inquisitive patient see his mistake. Incidentally, it increases his own confidence in the nurse. A flat refusal to gratify the patient's curiosity almost always antagonizes him, or, if he is a finer type, embarrasses him. Evasion of unanswerable questions requires more adroitness than a brilliant drawing-room conversation. A great deal of time is spent in training one to hold one's own in social intercourse. What the nurse says in the sick-room demands an equal amount of consideration. Unless the nurse trains herself to deal cleverly with the instinct of curiosity, she will blunder many times a day. Such a patient as E. J. Andrews, for example, who is accustomed to having a question answered when he asks it, cannot be met without skilled phrasing. We admire greatly the person who is ever ready with the polished reply. The ease and the finish of such conversational power is not learned in a day. So, in the nurse's effort to say the right thing, to give the finished professional reply, she will need to spend painstaking effort upon her preparation. She will not undervalue the importance that may lie in the selection of a single word.

When a patient begins to get well, curiosity is almost always evident. He calls it "taking interest in things again." Patients want to walk around and see something of their surroundings. In the home, patients are eager to see how the house looks after what seems a very long time.

Hospital patients on the road to recovery, usually show a lively interest in their neighbours. Sometimes a patient will try innocently to take apart some apparatus to see how it is made. Give him something to gratify his inquisitiveness—a puzzle, an ingenious device that is safe in his hands. Gratify his curiosity in some way that can do no harm. "I wonder" is not a desirable state of mind—particularly for the nervous patient. Coupled with the instinct of *manipulation*, curiosity works mischief if not properly directed.

The instinct of *play* is pitifully absent in very sick patients. It is sad to see little children too ill to want to play. Older patients, who have not forgotten how to play in health, completely lose all such inclination under the ravages of disease. However, play, like curiosity, reasserts itself when the patient begins to get well. Gentle, well-regulated play has its place in exhilarating and stimulating the patient. Play, as well as *constructiveness* and *imitation* are instincts taken into account in occupational therapy work. The nurse must share the patient's elation over a bit of work well done and relieve his perplexity over mistakes if she wishes to deal with constructiveness in a sympathetic way. The convalescent patient may be entertained by giving him some simple thing to construct, or, if he is not strong enough to handle materials, he will take delight in watching the nurse's clever fingers "make something." The nurse needs to know something of occupational

therapy in order to care for the sick. She should have enough knowledge at least so that she knows how to occupy the patient's mind with the proper things and to select suitable occupations for special types. Although occupational therapy is a field open to specialization, every nurse should know enough of the subject to make her generally useful and successful in her work, particularly with convalescents. Much of the work in occupational therapy is directed to engage the patient's instinct of constructiveness and it is with this part of the work that we are now concerned. Constructiveness, encouraged and directed, serves to develop the patient's initiative, to interest and to entertain him, to cure him perhaps of an unwholesome attitude of mind. Incidentally, he may be made a skilled craftsman and helped in a practical way, but this is a secondary consideration. There are many constructive activities from which the nurse may choose in occupying the patient. Knitting, bead-work, colouring kodak pictures, weaving, leather- and metal-work, basketry, making scrapbooks, carving, pottery—the list is long. Naturally, children receive more attention concerning the gratification of this instinct than grown-ups. It must not be forgotten that many an older patient is made blissfully happy by being allowed to do something with his hands—he is often highly entertained by attempting things ordinarily offered only to children, such as folding and cutting paper in all sorts of fascinating shapes from bears to

silhouettes, fashioning paper chains and boxes, experimenting with plastic work. Patients over-tired from being read to will hail with delight some simple occupation that stimulates the constructive instinct. Whatever the patient does, he must *enjoy*. A boy who can "see no fun in making bead chains and bags," may give absorbed attention to making toy aeroplanes and ships. The things that appeal to the constructive instinct often touch the play spirit as well, so that double good is accomplished. Something that "goes," even if only a top, always gives special delight to the maker. . . . The curative workshops, made so well known during the late war, prove wonderful places of healing. Patients with joints stiffened through injury learn to use them again by exercise on foot-power machines, manipulating handsaws, painting, making brushes, setting type, and so on. All of this work is done by appealing first of all to the constructive instinct. If used as a therapeutic measure, constructive activities are carefully chosen with well-calculated steps toward definite ends. The nurse must be quick to follow the suggestions outlined by the surgeon. . . . Whatever the character of constructive work, it must never be too complicated for the patient. Progress must be even and satisfactory. Blocking of the instinct by putting something too difficult into his hands, thus perplexing and discouraging him, will undo any good that may have resulted from the interest attending the initiative steps.

*Imitation* is particularly evident in ward nursing. One complaint or request starts another. One patient calls for another cup of tea. Comes a series of calls for tea. Often a patient wants something whether it is good for him or not, simply because he sees another patient have it. Some of the funniest happenings of the children's ward are the expression of this instinct. Imitation as it shades into *emulation* may be turned to good account in setting up nice standards for ward or community conduct. Patients who have never been clean in their habits, take extra precautions in eating or trying to keep their nails in a good condition, when they are drawn to observe other patients who are more careful. Mr. James says that emulation is the very nerve of human society. In all social service work this instinct plays a prominent part.

*Migration* seizes the patient usually as soon as his strength returns. Judicious little changes from his sick-room, of which he grows so painfully weary, prove beneficial in averting ennui. If the patient cannot be taken from his room even to the porch, he can be lured a-journeying with pictures of travel.

*Acquisitiveness* shown in the desire to collect and hoard things is always active in the children's ward. Children are made happy by their bed-side boxes which they cram with cards, pictures, and puzzles, together with special personal treasures. During convalescence, helping a child to make a

collection of some kind almost always proves interesting. Older patients often show a tendency to hoard a useless accumulation of stuff at the bed-side—usually as a precaution against their possible needs. There is a good reason, based upon hygienic principles for keeping such clutter from the sick-room. Bed-side bags, if used at all, should be kept free from useless things. Patients frequently stuff things under their pillows or the mattresses, with the thought that they may need these articles "when there is no one around to get them." It is interesting to note that just as these adaptive instincts help us in adjusting ourselves to a normal existence, they make themselves felt in the patient's effort to adapt himself to the sick-room life. All sorts of useless things find their way into the sick-room through the patient's desire to get together articles he fancies he may want. If the patient can be made to feel that his wants will always be met by the nurse, the hoard can be broken up without much trouble. However, we frequently encounter the type of patient who, like a child, wants to have his collection of this or that beside him, simply for the sake of having it. He is often upset if his desire is thwarted.

*Teasing* and *bullying* are not uncommon in convalescent wards, in homes unused to consideration in times of illness, and in schools. Stealing and destroying hospital property, the possessions of other patients, or of the community, must be dealt with as expressions of the predatory instinct,

dominant in lower types. *Shyness* is one of the most common instincts classed as anti-social. The nurse often notes patients who are inclined to withdraw from the comradeship of the ward. Such patients do not always seek solitude because they like it. They distrust themselves. They have had nothing in their lives to build up confidence. They feel that they are "not like" other people. They are more frightened than other types of patients by their new surroundings. Such shyness must be overcome before the patient can be made to relax. In social-service work, shyness is often difficult to deal with. Sometimes it is mistaken for what it is not. Not only children but older people in certain settlement districts and in the country will scuttle away at the appearance of a stranger, and come forth to speak a greeting with painful difficulty.

The anxiety of parental and conjugal love is poignant in sickness. Let the nurse have infinite patience with the mother who is over-anxious about her child, with the father who clumsily hinders more than he helps in his yearning to serve his family in the extremity of illness, and with the young husband who is perfectly useless from excitement. The grief of a parent baffled in the effort to protect a child, helpless under the power of disease, should be understood by the nurse as the expression of the thwarted *parental* instinct. Such grief may be beyond human control. Some of the most wonderful renunciations and sacrifices are made by par-

ents in the effort to save their children from disease. Their heroic action is the natural expression of this strong fundamental instinct. . . . Of the *sex instinct* the nurse sees a great deal in a variety of manifestations that must be studied closely to be understood. The "blocking" of the sex instinct is at the base of many a family and social-service problem. Passion and sex jealousy are too strong in their forces to be disregarded.

*Gregariousness* so natural to the human race is not absent in patients. Ward patients like to get together and "be sociable." The sun-rooms in hospitals are always popular places. Patients get tired of themselves. After an illness, a craving for human companionship is to be expected. Frequently, for this reason, convalescents see more of people than they should. The more contented a patient can be made without having a great many people coming in to see him, the better it is for him. Companionship is a strain to the patient. He cannot enter into association with other people without giving something of himself. The average convalescent has no strength to spare. Visitors are not to be encouraged, except in unusual instances. For his own good a happy medium must be struck, so that the patient has enough of companionship to keep him from loneliness and at the same time not too much to take more of his strength than he has to spare. Homesickness keeps many a patient from getting on as fast as he should. Some-

times in a ward after visiting hours, the nurse will observe some patient plunged into deepest gloom, caused by the fact that he has had no visitors. He gets no comfort out of the laughter and talk of other patients' friends. The nurse will understand the need of cheer at such times. A little extra attention upon the part of the nurse herself will often make the patient feel in a better frame of mind. In settlement nursing the nurse finds many types that need to have the gregarious instinct properly gratified.

The consideration of the *co-operative* and the *altruistic* instincts becomes particularly necessary in group study. . . . Sometimes in recovering from an illness, patients show a new wish to help others, a feeling of friendliness for humanity in general, a particular solicitude for those near to them. They rise from their beds literally new beings. To be sure, these new evidences of finer social instincts are often transitory. It is not long before the old selfishness reasserts itself. If the new conquers, there is a struggle. The nurse can do much to arouse and encourage these instincts. Sometimes a little tactful suggestion awakens new interests in the patient.

"Box after box of flowers this morning, Mrs. Worthington, what shall we do with so many? Should you like to share them with the children's ward?" Such suggestions on the part of the nurse often meet with quick response. It must be borne in mind, however, that a spontaneous generous

impulse is always more desirable than one which is prodded into existence. Moreover patients are quite like other people in not desiring to be told what to do in regard to their attitude toward others. Altruistic interests may be aroused by indirect impressions if the nurse is quick to seize her opportunities and not to press them too far. The habit of trying to interest private patients in charities or philanthropic movements of special interest to the nurse, is seldom in good form.

*Rivalry*, if serviceably modified, helps in group occupational-therapy work, in ward interests, in settlement achievements. A humorous aspect of rivalry is noticeable when patients talk over their operations. Each patient claims a unique experience.

The *religious instinct*, the unlearned "something" that calls forth worship, often dormant while people are well, springs into activity the moment death menaces. The nurse should show respect for religion, whatever its expression. The patient may be of another faith. The nurse does not give the slightest indication that she thinks a religion other than her own, "queer." Religious discussion has no place in the sickroom. The nurse will come in contact with all sorts of ideas and forms of worship. A discreet silence concerning her own conception of religion is the wise course. Sufficient that those about her are aware of her simple belief in Him who cares for humanity.

The *rhythmic instinct* responds to such treatment as we now see applied in musico-therapy. The magic of music in its healing power has been put to test so thoroughly that no one can doubt its place in caring for the sick. The choosing of a particular rhythm is not the least of the problems undertaken by the "musical nurse" working to get certain psycho-physiological effects. In recognition of the reaction from syncopated rhythm, such music is not "prescribed" for tuberculosis patients running a high temperature or for other patients who need to be very quiet. All the experiments in musical prescriptions regard the patient's rhythmic instinct from a therapeutic standpoint. More of the interesting field of musico-therapy will be touched upon under the sense of hearing.

Contemplation of beauty has long proved of value in the treatment of disease. In studying the history of nursing in ancient Greece, we learn that for certain patients "it was advised that they should look out upon green fields or be cheered by flowers and the sight of water." The patient need not be learned in art in order to respond to the beautiful. There exists an instinctive recognition of beauty and a delight therein, that is not dependent upon education. In general practice the nurse has not the advantages to elaborate upon this knowledge of the patient's probable response to beauty, but impressions such as she is able to create, may be far-reaching.

Sometimes in sickness incongruous behaviour has an aspect so comic that it is difficult for those about to suppress laughter, such laughter as springs from the instinctive response to the comic. Nothing hurts the sick more than to be laughed at. Occasionally we see patients who can enjoy a laugh at their own expense, but they are rare. We must refrain often from a normal expression of mirth lest we wound the patient. The nurse may thoroughly enjoy a comical incident and yet keep her feeling to herself. The comical must never overshadow other things of importance. No action, however clown-like upon the part of the patient, should engross the nurse to the extent that she fails with her usual care to note his symptoms.

It is well known that in our adjustment to the world our instincts from childhood on assert themselves in an order very generally recognized. Teachers try to make the most of special periods of development, so that when an instinct is most active, a good habit may be formed. There is an opportunity in children's wards particularly for the establishment of certain habits of conduct which will be of lifelong value. A child goes forth from the hospital with many good instincts stimulated. Unless the newly acquired habits of the child are encouraged, he lapses into the old ways and no permanent good comes from this part of his hospital experience. Suppose, for example, he learned there for the first time how to use his tooth-brush properly. In the follow-up work of the social-service

department, the child must be encouraged in his new habit. The instincts of constructiveness, as shown in occupational work, often disclose particular ability along certain lines which should be noted for the good of the child's future development. Older patients are often led to new habits of behaviour by their experiences during illness. The caution born of "a lesson" in the way of an illness that might have been avoided, may lead to more rational daily habits. An intelligent fear of unhygienic living is sure to be a good thing for the patient to take with him from the sick-room.

Let the nurse be prepared for instinctive behaviour in general upon the part of the patient. Instincts long in leash have free play during sickness. Do not expect E. J. Andrews to maintain the calculated, controlled behaviour habitual to him in health. His unveiled fears, his wrath over trifles, his supreme selfishness, his turning to religion—all these things reveal another man. The patient, more frequently than not, sloughs his conventional training for the time being. Sickness does a great deal of unmasking. The patient is much easier to understand than the guarded man of health. If the nurse once gets a good grasp of the instincts characteristic of human beings, she is on the road to "knowing what to expect." The primitive urge connected with all conduct, however trained, is particularly evident in the attitude of patients. The nurse will quickly realize that it is useless for her to try to analyze her

patients without taking instinctive tendencies into account. In her study of other people, she will not forget the part that instinct plays, even in the most conventional forms of conduct. She will not be misled by the fact that a great deal is "covered up" by professional and social form. He is a wonderfully controlled human being indeed who does not betray to the close student of bodily expression, something of what is behind his formal action.

The modification of certain instincts is the groundwork of general education. In getting a patient to inhibit a particular tendency, the nurse's tactics may be like those of a mother, who, in keeping a child from repeating an act, makes him feel the unpleasant results. Finally, the child leaves the forbidden object alone. Just so the patient who persists in doing the thing which retards progress may be persuaded to inhibit the act if he sees that he is responsible for undesirable results. However, the patient cannot be allowed to suffer, except to a limited extent, for his folly. A very little unpleasantness usually serves well to make the patient change his conduct.

The idea of getting well, the strong desire for a renewal of health, may inspire the patient to "be good." He will go through a great deal, endure all sorts of unpleasant treatments, if, always before him, he has the thought of being well once more. The nurse fosters this thought of restored health in her patients. She helps him to

visualize himself doing the things which, as a man in good health, he was accustomed to do. For the time being health is his ideal. If she has a patient who "doesn't want to get well," she has the task of helping create the desire for a renewal of life.

Unexpected capacities sometimes show themselves during an illness. An individual, who has always made the household miserable over minor ills, may show in a desperate illness a surprising capacity for suffering with quiet endurance. A person ordinarily showing little force or pluck, may put up a brave fight for his life. If he gets well, he is likely to exhibit a little more spirit, simply because he has found out by the one great struggle, that he has a reserve of strength.

It is not enough for the nurse to recognize instincts and the natural accompanying feelings. She must know how to control instinctive conduct, how to avert harmful emotions. Further details concerning specific ways of handling emotion will be found in the chapter upon *feeling*. The nurse may add something to the observations upon instincts every day of her career.

*The nurse's own instincts.*—The nurse's study of instincts as expressed in others will help her to understand her own instincts much better, and to judge them more impersonally.

Upon entering the training school or any new field of work her instinct of *imitation* is of great help to her in adapting herself to new ways. It

is hard for her at first to take in the reasons for many things. She does well to imitate what she knows to be the standard of conduct for which well-defined reasons will soon be apparent to her. On the other hand, nothing can be more fatal to the nurse's development than the acceptance of ideas in slavish fashion. There should be less disposition upon the part of older nurses to tell probationers what may be the most distorted opinions concerning the profession. Let the young nurse be strong in her determination to form her own judgments. Her one wish will be that her standards may be right. She will be slow in coming to conclusions. Emulation of the highest ideals does not mean mere copying of conduct. Through the study of such ideals the nurse finds herself unwilling to be an inferior or a commonplace human being. She wants to be the best type of nurse. She learns to discriminate very soon between good and inferior service. Never, in a weak leaning upon other people's ideas, does the wise nurse think of her profession in terms that belittle it.

The curbing of *curiosity* that is vulgar and little, is one of the nurse's most important obligations. "There is a mean curiosity, as of a child opening a forbidden door; or a servant prying into her master's business;—" says Ruskin, "and a noble curiosity, questioning, in the front of danger, the source of the great river beyond the sand—the place of the great continent beyond the seas—a

nobler curiosity still, which questions the source of the River of Life. . . ." This same noble curiosity of which Ruskin speaks leads likewise to artistic and scientific study, to the most careful inquiry concerning the ways of perfect service. It holds the nurse back from undue prying into the private affairs of her patients and friends.

The nurse needs to keep active her instinct of *play*. No greater mistake can be made than suppressing or ignoring the desire to "have fun," to play, with the spirit of a child. The character of the game may change, but certainly no one should ever grow too old to play. Oh, do not say that it is "natural to settle down as one grows up!" Surely the world holds happy possibilities of fun for every age. Spontaneous activity, a delight in movement for movement's sake, a care-free response to "a good time," is what the nurse needs between her work and her rest. Tennis, golf, swimming, tramping, riding, collecting wild-flower specimens, taking pictures—all, as play, offer wide diversion. Dancing is one of the best forms of play. Improvising dances to phonograph music makes a fine frolic. Various games and charades are not to be passed by as "silly." It is tragic when a human being grows too stiff and self-conscious to enter wholeheartedly into play. A grown-up who can join in a romp with children or with dogs, gets far more out of life than one who sits by and watches. Is it not possible to play without losing one's dignity? There are refinements in play as well as

in other activities. One need not become a hoodlum or a clown in order to respond to the play spirit. . . . By knowing how to play herself and how to get others to play, the nurse may establish sympathy and comradeship that could not be brought about in any other way. Individuals—even nations—may be brought together through play. During the recent war, the American directors of the soldiers' play proved that when soldiers of other nations learned our games, they "understood" our boys better. Something of a nation's play spirit is shown in its characteristic games and the way they are played. In social service work the nurse is often called upon to deal with factions. Difficulties may be quickly cleared away through the comradeship of play.

If the rules of the training school do not control the decoration of the nurse's rooms, many young women give free rein to the instinct of acquisitiveness. Collections of kodak pictures surround their mirrors, dance programs dangle from inverted Japanese umbrellas, Christy pictures form a frieze about the wall. Many a bonfire may well be made from the hoards of useless, undesirable things with which nurses fill their rooms. It is deplorable, if, when a nurse gets out of training and can plan the sort of room she wants, it shows no signs of increased refinement of taste. Sometimes it happens that a nurse develops an austerity of choice which makes her room resemble a cell. The training of a nurse should make her intolerant of having

a useless lot of material things about her. At the same time, no one needs more than the nurse, an attractive environment when she is not on duty. There are collections well worth while that add greatly to the nurse's enjoyment of her room—well-bound books by good authors, truly artistic pictures, good examples of plastic art. Such things give charm and colour to a nurse's life. Almost every girl has her treasure chest into which go fine linen, embroidery, and lace for the time when love comes by. Such storing away for the wonderful mating time is a natural expression of acquisitiveness, for the nurse as well as for other girls. . . . Whatever the nurse's particular bent of acquisitiveness may be, let her develop discrimination. True appreciation of what is fine and artistic will make the nurse prefer to have only one book or picture that is worth while to a cheap collection in poor taste. A bit of real lace will give more pleasure than yards of imitation.

The retractive instinct sometimes asserts itself in the nurse herself when an unusually trying situation develops. Delirious patients at times strike terror to the nurse's heart. In delirium, the patient is usually beset by fear of some sort and attempted flight or struggle results. The nurse, who is not sure of her power of control, becomes afraid of her patient. If she is successful in quieting him, she does so by removing his fears or diverting his mind. She immediately loses her control if the patient sees the slightest expression

of fear upon her part. A sudden demand upon a young nurse for an advanced nursing procedure, sometimes makes her feel timid. Always the nurse should check the first instinctive fears aroused by various phases of her work. The nurse who is easily panic-stricken is of little service. Do not look for the grim aspects of nursing. When you must face them, have no fear. There is enough that is joyous and satisfying in the profession so that there is no reason to be a-tremble with anxiety over the frightful which *might* happen. A high heart always!

A wholesome fear—the sort of fear a nurse should have—is that of spreading disease. Well-directed fear of community danger stimulates the nurse to the highest professional effort. Because Florence Nightingale was afraid of dirt, one of the first requisitions she made for her work in The Barrack Hospital at Scutari was for scrubbing brushes.

The nurse may find certain types of degenerate patients repulsive, or some diseases naturally loathsome. She needs to keep a strong grip upon herself—this instinctive revulsion must never be betrayed by so much as the quiver of an eyelash. Patients are very sensitive about being obnoxious to those about them. Some patients dread taking an enema or having dressings done, because they do not want to "make things disagreeable." They look for the signs of revulsion on the part of those attending them. It is always a relief if there is

no such evidence. "Maybe it isn't as bad as I thought," the patient reassures himself comfortably. Nursing demands the control of the actor. Together with all her other powers, the nurse needs to know how to act many a part. She must be quick to take her cue. She must show none of the amateur player's uncertainty. She must never be known to be acting a part. Professional poise shows neither fear nor revulsion. As the nurse rises to the finest conception of her service, she *knows* neither fear nor revulsion, except where such instincts are turned to good ends.

Self-assertion sometimes makes an older nurse unpopular. The more she learns, the more she shows her feeling of superiority over younger nurses. Nurses who have specialized in various fields of nursing, detract from their efficiency by complacency of manner. Head nurses, sometimes carried away by a sense of importance, take on an arrogant manner of giving orders. One of the marks of those best fitted for places of responsibility is the utter absence of pride and vanity. The preening of a nurse robs her uniform of its dignity.

The unfortunate habit of many nurses in training—and out—of "borrowing" without the owner's consent, or "forgetting to pay back," is closely akin to the predatory instinct and needs to be closely curbed.

Shyness can be overcome by meeting other nurses half-way. It is never desirable for a nurse

to live too much to herself. It is worth while to form warm, sincere friendships. It sometimes happens that a nurse is not at all shy with other nurses, but cannot meet people in general without painful embarrassment. She "has nothing to say." She needs to develop a cosmopolitan air which comes through wide study and an acquaintance with things outside her profession.

Much of the mother instinct expresses itself in nursing. Every good nurse shows a certain "mothering" of her patients. Always a natural instinct, it leads the nurse to a broader view of a woman's obligations. The expression of the mother instinct should not be confined to bringing up one's own children. The sick, the sorrowful of the world are ever in need of woman's tender concern. The nurse, above all women, knows the joy of administering to the wants of many. What was it, but a glorified expression of this mother instinct, plus the altruistic, which drew Florence Nightingale to her supreme sacrifices in caring for the soldiers of the Crimean war? There are many women in nursing history who have chosen a single life in order that they might give themselves devotedly to the profession. Not less than mothers of children have these women known the joyful expression of the instinct. Nurses who marry and cuddle their own babies, cannot forget the great cry of the world for the mother care. Less than many other women, does the nurse who is married, withdraw into the little circle of her

own home life. Her whole training tends to develop her social conscience. She learns how to administer to outside needs without neglecting, in any detail, her own household. It is oh, so difficult to have patience with women who prate about the all-absorbing duty of a mother to her children! Of course she has a duty—so has she a duty to other children not her own, a duty to the sorrowful, the care-worn, the afflicted of the world. It is sad to see love of her own deaden a woman's broader sympathies. She is indeed vulgar in a pitiful sense. She who thinks she needs no pity in her smug care of her family, needs it, not only for herself, but for her children who naturally reflect her narrowness of vision. The "button-molder" mother—what will stay her in this injustice to her own?

The nurse learns a finer kinship than that expressed in the companionship of friends and family. Her world of service holds satisfying comradeship. She is never lonely, although in her work she may be kept from many so-called entertainments. She enjoys a good play, a gay party, the more because she is not surfeited. Her zest for the out-of-doors is increased by her sick-room experience. . . . Satisfying as a nurse may find the kinship of service, she will not disregard the need of associations outside of her profession. When nurses are off duty they should not "talk shop." Not all of a nurse's friends should be other nurses. In order to develop the highest type of friendliness

and sociability the nurse must enter into sympathetic relations with a great variety of people.

Loyalty to her patients and her training school is a paramount consideration of the nurse. In co-operating with physicians and other nurses, she learns team-work to perfection. In the care of patients, all personal dislikes and antipathies are put aside. A nurse should be able to co-operate with her dearest enemy in a necessary service. She is called upon many times to subordinate her personal inclinations and gratifications in co-operating with the demands of service.

A nurse's so-called "religious instinct" may be either intensified or deadened by her work. Much depends upon how she views her profession. The great freedom of the nurse may be her downfall. She may lose sight of the importance of spiritual concern in her life. It is very evident that many nurses have their feet very firmly planted upon the earth. Some of the most intellectual are the most materialistic. If a nurse has a spiritual quality, it is instantly recognized. It lifts her somehow above other nurses who haven't it and increases the confidence of patients in her service. The most heroic achievements come from the nurses who are spiritually sensitive. These are the nurses who receive the greatest satisfaction in the profession. It is a question whether a nurse can fully grasp the idea of education from the standpoint of service, unless she has this quality. There are many ways in which a nurse may be

quickened to higher thoughts if she will hold herself open to such impressions. If her study is undertaken in the right attitude, she will feel that "all science leads up to God." In her wide relations with people she will learn that religion in its deepest significance is something bigger than creed. Her own religion will be her protection in her work.

Vincent de Paul said to his Sisters of Charity:

"My daughters, you are not 'religious' in the proper (monastic) sense, and if there should be found some marplot among you to say 'It is better to be a nun,' ah! then, my daughters, your company will be ready for extreme unction. Fear this, my daughters, and while you live permit no such change; never consent to it. Nuns must needs have a cloister, but the Sister of Charity must go everywhere. . . No other monastery than the house of the sick. . . . You must . . . be even holier than nuns, since you have greater temptations and less security; if you are not truly holy you shall certainly be lost. . . . You have no grating to shut you off from the dangers of the world; you must erect one in your own inner self, which will be far better."

So it is with the nurse of today, bound by no vows, no religious obligations, she needs a barrier against the dangers of her profession—that of her own spirituality. The term "religious instinct" has proved unfortunate in carrying rather a narrow or perverted impression. Some psychologists

pass over the instinct entirely. Without entering into a discussion as to whether religion is a natural instinct, let us recognize and try to understand, the "reaching out" that is a part of every normal human being. We must call it religious for want of a more adequate term, which does not arouse scientific controversy.

The nurse may be amazed at her own capacities developed during her training. She may surprise herself constantly by accomplishing things she never dreamed that she could do. Finding out the possibilities of conduct is a part of education, to be studied without too much self-depreciation.

## Definitions

"*Reflexes* include those connections of events in the body—sometimes felt in sensation, sometimes not—with movements, in which the act follows the impression automatically, without either intention or control on our part (*e.g.*, turning in the toes when the sole of the foot is tickled, the contraction of the pupil of the eye in response to light, or sneezing when the membrane of the nose is irritated)."

"*Instincts*, as now commonly defined, include reflexes and all other connections or tendencies to connections amongst thoughts, feelings, and acts which are unlearned—are in us apart from training or experience. *Anything that we do without having to learn to do it, in brief, is an instinct.* Thus, crying when pain is felt, starting at a sudden noise, feeling

fear at large, strange, moving objects, feeling anger when food is snatched away from one, and laughing when tickled, are instincts of babyhood; to feel jealousy when rivalled by one of the same sex and to act conspicuously when attracted by one of the opposite sex, are instincts of youth. The common usage of the words instinct and instinctive differs from the psychologist's usage. People commonly say that they do or feel certain things instinctively when they act or feel without deliberation or forethought or clear consciousness of what or why; *e.g.*, 'He instinctively lifted the glass to his lips!' . . . An instinct means an act that is the result of mere inner growth, not of training or of experience."

"*Capacities*—The inborn qualities which are the partial basis for the development of the mental powers might be called instincts of possibility rather than of fact, they being qualities which will result in the presence of the powers or habits corresponding to them when the proper circumstances arise. The common word for these instincts of possibility is *Capacities*. Thus the capacity for composing music means the qualities which, though themselves unknown, will, when the proper time comes, blossom out in the power to compose music and the habit of doing so." (E. L. THORNDIKE, *Elements of Psychology*, p. 15 and 16.)

"*The Control of Original Tendencies*—Although instincts and capacities are, in and of themselves, removed from human control, their later modifications are not. They are a fund of capital given by nature which may be invested in all sorts of ways.

We make the most of nature's gifts by (1) encouraging the useful instincts and capacities, (2) inhibiting the harmful ones, and, (3) by so arranging life's work as to have natural tendencies assist rather than oppose it.

(1) Useful instincts and capacities are encouraged: (a) by being given exercise as soon as they appear and frequently enough to result in the formation of habits before the instinct wanes, and, (b) by making their consequences pleasurable.

(2) Harmful instincts and capacities are weakened or inhibited: (a) by depriving them of exercise, by not allowing the situations which would evoke them to appear, (b) by forming, before the tendency is fixed, the habit of meeting the situation in some other way, and (c) by making their consequences intolerable.

(3) No general answer can be given to the question suggested by (3), but one or two illustrations will show the gain to be everywhere expected from the recognition of and the allowance for natural tendencies. A man wanted a pile of rocks removed. He taught his boys to play that there was a fire in a hole some distance away and that the rocks were pails of water and they firemen. In a few days not a rock was left. At a city playground the older boys bullied and teased the younger ones. The sagacious director picked out several leaders from among the older boys and appointed them policemen to enforce fairness and to protect the "little kids." The instincts of activity and combativeness and emulation were now turned to useful ends. Bullying the small boys gave way to governing the large ones." (E. L. THORNDIKE, *Elements of Psychology*, p. 196.)

## Questions for Study

1. What behaviour is mechanical?
2. What is the difference between reflex behaviour and instinctive behaviour?
3. What is the general reason for fear upon the part of patients?
4. Give an example of the retractive instinct as manifested by a patient under your observation.
5. What are some of the "little fears" often manifested by patients? Give examples.
6. Give in your own words (direct address) an explanation to a child of six, that he is to take an anæsthetic.
7. What is the result of "blocked" timidity and fear? Recount some undesirable occurences caused by such blocking.
8. Have you observed any accidents that were the result of the repulsive instinct?
9. How is self-assertion affected by a life of failure and unhappiness?
10. Tell about a patient under your observation who needed to have his pugnacity aroused.
11. What acts as a red flag to combativeness?
12. What are the adaptive instincts? How are they modified in the sick-room?
13. A patient hears in the night the stir attending the death of the patient in the next room. He asks, "Is the patient in the next room worse? What is going on?" What will your answer be?
14. Give an example of good conduct brought about by emulation.
15. Which sex shows more acquisitiveness as a general thing in sickness?

16. How will you deal with the over-gregarious patient in the sun room or the convalescent ward?

17. Can you give an example of the so-called religious instinct as expressed in a child who has had no religious training or experience?

18. How may notice of the comic be held in check in the convalescent ward?

19. How does the law of transitoriness of instincts make itself felt in public-health work?

20. What harmful instincts and capacities in each of our five nurses are to be inhibited? What useful instincts encouraged?

21. What points are to be observed in weakening or inhibiting harmful instincts?

22. Give an illustration of a patient's acquisitiveness?

23. Give an illustration of modification of instinct accomplished in public-health work.

24. What method of modifying is most used with patients?

25. How may a nurse change the patient's antagonistic feeling for the hospital and everything connected with it?

26. How may the nurse make use of the idea of fighting in dealing with her patients?

27. Give an illustration of a harmful instinct in a patient, which, during illness, needed particularly to be inhibited in order to hasten the patient's recovery. Tell how the inhibition was accomplished.

28. How should you go about inhibiting an undesirable community tendency?

29. From your observation of convalescent patients, give examples of how natural tendencies may help rather than complicate the order of the ward.

30. How may you inhibit Mrs. Telford Worthington's undue curiosity about hospital affairs?

31. What are the purposes of occupation which gratifies the instinct of constructiveness?

32. What is the mechanism by which recovery is brought about through occupational therapy?

33. Select some occupation, gratifying the instinct of constructiveness for each of our five patients during convalescence or prolonged illness. Give reasons for the difference in their occupations. Indicate the probable reaction of each patient.

34. Which one of our five patients will respond most quickly to an appeal to the play instinct?

NOTE: The purposes of occupation as stated by William Rush Dunton, Jr., in his book, *Occupation Therapy*, will be helpful to the nurse:

1. "The primary purpose of occupation may be said to be to divert the patient's mind from unpleasant subjects, as in the case of one depressed. Or in a case of dementia præcox where the subject is given to day-dreaming or so-called mental rumination, occupation is given to keep the patient's train of thought in more healthy channels. In a case of mild excitement occupation will keep the patient's mind more continuously on one subject than it is possible if he has not this stimulus to control his attention. In cases of marked excitement, it is usually impossible to use occupation in treatment which is usually directed toward securing rest. When convalescence is begun, occupation will be of value.

"In cases of dementia of various sorts the purpose may be to re-educate, to train the patient to develop

the mental processes by educating the hands, eyes, muscles, etc., just as is done in the developing child.

2. "Another purpose of occupation may be to give the patient a hobby which may serve as a safety valve and render the recurrence of an attack less likely.

3. "Still another purpose which is often resorted to is that of giving the patient a means of livelihood after leaving the hospital, it being deemed wise to give up the former vocation. A school-teacher whose visual defect had forced her to give up her position, was so unfortunate as to suffer an attack of depression. During this she was taught basketry and was especially directed to the work by touch rather than by sight, in order to eliminate eye-strain. She developed sufficient skill so that her work had market value. . . .

"It is the opinion of some that the patient should be instructed in a craft until he has sufficient skill to take pride in his proficiency. While this is proper, I fear lest some of its advocates lose sight of the fact that specialism is apt to cause a narrowing of one's mental outlook, and also that the individual with a knowledge of many things has more interest in the world in general. I believe it is, therefore, well for the patient to have other occupations besides a craft, bearing in mind that occupation is not restricted to crafts alone. Games, exercises, music, reading, etc., are quite as important. Rest is secured and fatigue is avoided by change. The patient should have a major interest and several minor ones to direct his thoughts in different channels. . . .

"The *mechanism* by means of which a recovery is

brought about has been made the subject of considerable inquiry. It may be summed up by the one word, *substitution*, or, if one prefers, *replacement*. It is well known that but one idea can occupy the focus of the attention at a given time. Our depressed patient who is brooding over the fancied sin he believes he has committed pays little attention to what is going on about him. Repeated efforts to get him interested in something fail but success comes after a time, and we find him watching a baseball game with interest. His attention is so taken up with the desire for the home team to make the winning run that for a little time the depressive idea is driven from the focus of attention and replaced by the idea of baseball. Other interests may be given him and accepted until at last he regains better control of his attention and can voluntarily drive out the depressive thoughts."

### References

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### Questions for Re-education

1. With what special capacities is my training concerned?
2. Have I a capacity for originality?
3. Have I a conscientious fear of spreading disease? Am I just as careful about disinfection and cleanliness whether I am alone or under observation?
4. How has my instinct of acquisitiveness expressed itself thus far in my life? What has my life been, marked by a calendar of collections? What do

the various changes indicate? Should I be satisfied with these indications?

5. Am I curious about higher things?

6. What can I do with my hands to entertain or instruct my patients?

7. How does responsibility affect me? What is my manner to those under my direction?

8. Am I shy or over-gregarious?

9. What lack of development is indicated if I am always wanting to be in the company of others?

10. Have I an appreciation of the comic when I am the centre of the situation? Can I enjoy a laugh at myself?

11. Have I forgotten how to play?

12. Am I truly religious? Do I ever hide my response to religious influences when in company with those who show no such feeling?

13. What difficulties have I had in dealing with other people that might have been obviated if I had been more co-operative in spirit?

14. Are my altruistic instincts foremost in my wish to become a nurse?

15. What tendencies should I inhibit?

16. Is my knowledge of English extensive enough to enable me always to choose the right word? Do I appreciate a finished phrase when I hear it? When has a clumsy answer made a situation difficult for me?

17. What are my strongest instincts?

18. Am I sensitive to rhythm?

19. How does fear affect my conduct? What are my little fears?

20. Do I ever show vulgar curiosity by asking my patient questions about his personal affairs? Have I learned to be impersonal with my patients?

# CHAPTER V

## HABIT

"All our life, so far as it has definite form, is but a mass of habits,—practical, emotional, and intellectual, —systematically organized for our weal or woe, and bearing us irresistibly toward our destiny. . . . We are subject to the law of habit in consequence of the fact that we have bodies. The plasticity of the living matter of our nervous system, in short, is the reason why we do a thing with difficulty the first time, but soon do it more easily, and finally, with sufficient practice, do it semi-mechanically, or with hardly any consciousness at all."—WILLIAM JAMES.

TAKE up a glove you have worn, fill it with air and you see it take on the habitual curves of your hand. Look at your row of shoes—all of them bearing the same impress, more or less definite, according to the length of time you have worn them. The heels are "run over," the right a trifle more than the left, perhaps, or the soles becoming thinner toward the centre. The baby's tiny shoe is treasured because it shows the place where baby always stubbed his toe—something of the wee self lingers about the shape of the much-worn foot-

covering. Inevitably, the things we wear take on the stamp of habit. Mothers know where to look for the holes and the worn places in the various garments of the household. Clothes do not look new long. They soon begin to take on the characteristics of the wearer. We say of clothes that they "look like" the owner. Human beings, soon—oh, very soon, after their appearance in the world, begin to show the marks of habit. Any one studying the nervous system is impressed by the delicacy, the plasticity of that living matter, sensitive to any kind of habit-formation. Yet individuals who long to be a power in the world fail merely because they will not make use of habit-formation. Parents who would make the greatest sacrifices to secure a child's well-being, will not take the care to establish an understanding in the child of habits which make for a fine existence. Is it because the setting up of habits is thought to be a tiresome thing? Is the beginning struggle, the detail, the regular insistence of it, too great a price to pay for the ultimate freedom and power? Truly, "only the man is free who has fought himself free."

If the nurse comes to the training school with certain well-formed habits which she can transfer to her work as a nurse—such as habits of cleanliness, precision, orderliness, cheerfulness, sincerity, self-reliance—she will be so much ahead. To become a nurse demands the setting up of certain habits necessary in caring for the sick. If a

probationer is a "bundle of habits" that have no place in the profession, if she has no idea how to form a new habit, nor the inclination to learn—the outlook is indeed dark for her. The ability to become a nurse, after all, resolves itself into the power to form the necessary personal and professional habits.

Isabel Terry's friends said of her when she left for the training school:

"Isabel can never become a nurse—she is too self-centred. She likes to do things only for people she is particularly interested in and she likes to work only when she feels like it—oh no, Isabel will never make a nurse."

Isabel Terry proves that she has one great thing in her favor—she is not rigid. She is adaptable and plastic to the impressions of her new life. She has the good sense to recognize the habits that stand in the way of her becoming a nurse. She calls her bad habits by the right name,—a fine sort of courage not encountered in everyone who claims to have a desire "to improve." She develops an interest in humanity which pushes her selfishness out of existence. "I never knew that there were so many fascinating people in the world," she declares. "Nor so many that need help." She directs her exercise wisely, thus eliminating the habit of spasmodic play. She learns how to study, which involves an entirely new attitude toward her books, learning to concentrate, to memorize without dawdling, and to make practical application

of what she finds in books. Her natural deftness she turns to good account. Her nursing touch is very gentle and quick, lacking only in sureness, which is gained by closer attention to the rules of form and execution. She is drawn to occupational-therapy work in which her cleverness at designing, her ability to tell stories entertainingly, prove of great value to her. She forms new habits of resoluteness born of a very real interest in the art of caring for the sick. . . . She will surprise her friends by becoming a nurse—a very good nurse.

Young women who appear unfitted for nursing often turn out to be satisfactory nurses, because they possess the power to set up the necessary habits. Quite as often, those seemingly "cut out" to be nurses, fail, from the lack of ability to correct grave, hidden weaknesses. The "faculty of effort" is essential for success. William James says:

"Keep the faculty of effort alive in you by a little gratuitous exercise every day. That is, be systematically heroic in little unnecessary points, do every day or two something for no other reason than its difficulty, so that, when the hour of dire need draws nigh, it may find you not unnerved and untrained to stand the test. Asceticism of this sort is like insurance which a man pays on his house and goods. The tax does him no good at the time. . . . But, if the fire does come, his having paid it will be his salvation from ruin. So with the man who has daily inured himself to habits of concentrated attention, energetic volition, and self-

denial in unnecessary things. He will stand like a tower when everything rocks around him, and his softer fellow-mortals are winnowed like chaff in the blast."[1]

It is because young women of today have so little in their lives to make "the faculty of effort" strong and ready that they give up in such large numbers when undertaking any big service. Fortunate indeed the nurse who enters training with some knowledge of what "gratuitous exercise" of this valuable faculty means. Such a nurse finds the formation of new habits comparatively easy. She is not one to give up her training because it is too hard. In return for her "asceticism" she gets more real joy out of her training than any other type of nurse. The women soft from disuse of this faculty hinder more often than they help.

The differences in our five nurses is due, not so much to their instincts, for, "instincts are fairly constant, with all members of the same species, varying only in intensity"; it is in their habits that the variations occur. Each girl has come from a different part of the country to which she has adapted herself in particular ways. Isabel Terry's habit of speech—her southern drawl—is in sharp contrast, for example, to the western accent of Mary Anderson. Each girl has a different way of saying things—each using phrases, provincialisms, natural to the place in which she has lived. Charac-

[1] James, William. *Talks on Psychology*, p. 75.

teristic habits of all kinds have been established through family and community life. Each girl has modified her instincts in a different way. Elizabeth McCaskell, whose experience has been more limited than that of any of the other girls, is inclined to think her companions "queer" because they act and talk in ways to which she has not been accustomed in Grayville. She notices little differences, which are not included at all in the differences as Frances Tracy sees them. In the nurse's study of herself and others she will recognize broadly, that in the main, it is habit that makes people different; moreover, she will trace the far-reaching reasons for the variety of habits.

Re-education involves the recognition of habits already formed that are wrong and of habits that need to be formed. There can be no really valuable habit-formation without this frank preliminary analysis. In connection with this analysis, as pointed out by F. Matthias Alexander in his book, *Man's Supreme Inheritance*, it is essential to understand the difference between the habit that is recognized and understood and the habit that is not understood. The first can be altered at will. The second cannot be radically changed. It is possible of course to set up an artificial change of conduct by the carrying out of rules and regulations accepted without question or deliberation, but such alterations of habit as may be involved, can be of no real benefit in the true re-education of the individual.

The steps indicated by psychologists to be taken in altering a bad habit, are, in brief, as follows:

1. Admit the bad habit—unreservedly recognize that it is wrong.
2. Study thoroughly the ill effects of the bad habit upon yourself and others.
3. Consider the effect of the corrected habit upon yourself and others.
4. Learn specifically how to deal with the bad habit.
5. Eliminate all resistance to the new way of doing. Be plastic.
6. Understand and execute the laws of habit formation:[1]
7. Keep up your enthusiasm. Do not subject yourself to influences that will interfere with your resolve to form the new habit.
8. Study the phenomena of "plateaus." Learn how to obviate plateaus in your habit-formation.
9. Be sure of thorough conscious mastery, before giving over the movements to the subconscious self.

It is difficult to think of any new desirable habit that does not involve an alteration of the old. Therefore in re-education the nurse is largely occupied with breaking up bad habits in order to form the new.

It would be helpful if we could see motion pic-

[1] Colvin and Bagley, *Human Behaviour*, p. 168.

tures of ourselves going about the ordinary things of life—talking, walking, sitting, standing—all the activities to which ordinarily we give no thought because we have set up certain habits and these many times repeated actions take care of themselves. What a chorus there would be!

"Oh, do I throw my shoulders about like that?" "I never realized before that I twist my face up so when I talk!" "I'll never shake hands like *that* again—" "Why, I look as if I am going to wobble off the chair—I am only trying to get up!" "Such a walk! I bob up and down like a jumping-jack." "Do I strike a grotesque attitude like that when I stand still?"

The nurse, seeing herself upon the so-called silver sheet, in "A Morning on Duty," would have her eyes opened to many deficiencies!

"*Oh*, what a way to lift a patient's head! And how clumsily I manage that tray—I should think the patient would wish me well out of the room. What a smirk—do I think I am smiling? Now I am so interested in trying to remember whether I have everything ready for the doctor that I am scowling as hard as I can, without knowing it at all. Poor patient—he thinks I am angry about something or don't like nursing him. See how disturbed he looks! And there I am sailing about the room completely oblivious of his discomfort. The way I 'rise to a superior'—I look as if I were made of wood. Can't I be respectful and easy at

the same time? I am only trying to hide my embarrassment as I enter that room, but I seem to be trying to attract attention instead. Surely I ought to know how to seat myself without falling into a chair with a flop like that."

Safe to say, after viewing such pictures, the nurse could no longer tolerate her way of doing things. Since such illuminating study is not possible ordinarily, the nurse may project herself in imagination upon the screen and thus visualize her actions the more easily. It is possible to get valuable hints about our conduct by watching the effect upon other people. The mirror too may become a useful agent, if we can learn to look at our reflections without self-consciousness. We must "stop to think" before we can alter our habits. The admission of the wrong habit must be free and whole-hearted. It is much easier to coddle and excuse a fault than it is to denounce it. This listing of habits, physical, mental, and emotional, is not to be finished in a day.

To apply the steps to be taken in altering a bad habit to Ann Sherman when she awakens to a realization that the habitual posture of her shoulders, back, and hips is wrong:

Ann will first study the ill effects of the bad posture, using some such detailed outline as may be found in various books of physical control. The following summary is made from Mr. Matthias Alexander's exposition of the subject:

| | *Result* | *Result of New Co-ordination* |
|---|---|---|
| Wrong posture of shoulders, hips, and back. | 1. Minimum intra-thoracic capacity. | 1. Normal intra-thoracic capacity required for health. |
| | 2. Organs within the thorax harmfully compressed. Strain on heart. Lungs not adequately employed nor sufficiently aerated. Improper distribution of the blood supply, of the lymph fluids, contained in organs of elimination. Digestion not normal. Proper functioning of vital organs impossible. | 2. Freedom of organs of thorax. Heart functioning without strain. Lung expansion increased. Blood supply properly distributed. Lymph fluids carried normally. Vital organs functioning properly. |
| | 3. Interference with general nutrition. | 3. General nutrition going on without interference. |
| | 4. Undue intra-abdominal pressure; harmful flaccidity of abdominal muscles; dropping of the viscera; imperfect functioning of the liver, kidneys, bladder, etc. | 4. Freedom of pressure intra-abdominal; new firmness and power of abdominal muscles; viscera rise again to normal place; improvement of figure; normal functioning of liver, kidneys, bladder, etc. |
| | 5. General disorganization. Loss of internal massage; condition of stagnation, fermentation, etc., causing manifestation of poisons which more or less clog the general organism. Slow poisoning or acute attack by invading bacteria. | 5. Restoration of normal working order of system; internal massage active; throwing off of waste from body accelerated. New tone to system; renewed zest and strength. Resistance to disease increased. |
| | 6. Less mental power. Sluggishness of mind. | 6. Increased mental activity. Freshness of mind. |

From this, Ann perceives that she is injuring her general organism and that it will be worth while to form new habits of posture. Not only is the wrong posture unlovely to look upon—it is doing her real injury. In its effect upon others, Ann sees that no one can like to behold such physical ugliness. Moreover, she is held back in her wish to serve others by habits of body that make her less capable. She is at a decided disadvantage in her nursing procedures. She cannot do them with the skill and freedom which is possible with a perfectly poised body. She is tired by her work unnecessarily. Therefore she is unable to give the highest type of care to the sick. Ann visualizes herself as she would be, free from the bad habits of posture. She sets to work to find out which muscles are doing work for which they were not intended and which are imperfectly controlled or undeveloped. She measures her chest expansion and compares it with what it should be normally. Correct position of the shoulders and the back involves correct breathing. She learns not to throw back her shoulders in taking a deep breath. If she "has a hollow between her shoulder blades" she knows her upper chest is expanded unduly. She strives for a broadening and flattening of her back. Her spine lengthens, instead of shortening. As her chest lifts naturally, her organs fall into proper place. At first she feels a certain effort, even a little pain from the stretching of long unused muscles. There is no habit harder to alter

than the incorrect posture of the shoulders, since it involves alteration of the breathing. Thorough conscious mastery takes a period of considerable time. It is so easy to slip back "just for a little while" into the old habits of attitude. Unless Ann has a very strong determination, she will fail to rid herself entirely of the posture which has been characteristic for so long. On the other hand if she has the courage to "fight herself free" she will enjoy the full return of self-discipline. With the new posture of her back and hips her walk takes on new grace, and, as is almost always the result of a new desirable habit, there are indirect benefits, at first not taken into account. When Ann is tired, she will need to put forth an extra effort and to think of the benefits of the new habit, otherwise she will succumb to the influences bringing about "plateaus."[1]

When our five probationers start their studies there is not such a marked difference in their grades as appears later in their training. At first the newness of their work spurs them all on to do their best and their learning progresses rapidly. As time goes on, Elizabeth McCaskell is heard frequently to remark that she never has time to study Materia Medica and Mary Anderson thinks she would like chemistry better if she had a better teacher. Both fail repeatedly in recitation and feel discouraged. They are at a standstill. In other words, they have reached a plateau stage in

[1] Colvin and Bagley, *Human Behaviour*, p. 175.

their work. They try to excuse themselves for their lack of progress and fall into the common habit of giving reasons that are false—not false in the sense that they are deliberate falsehoods, but because they do not get at the true causes. In Elizabeth McCaskell's case, the real reason for her discouragement lies in the fact that she has not had an adequate preparation for Materia Medica—consequently she finds it hard and uninteresting. She puts off getting her lessons until the last minute. She would "have time" for her problems in drugs and solutions if they did not seem so hard to her. A little clearing away of haziness in arithmetic would dispel her discouragement. Mary Anderson is trying to find some reason outside herself for not liking chemistry. She has not learned to connect the subject in a practical way with her everyday experience, therefore it seems dull to her.

What brings about plateaus in the nurse's work?

1. Discouragement, due to lack of faith in one's ability.

2. Fatigue of body or mind. It often happens that in the strain of the first few months' work, a nurse becomes somewhat tired. Without realizing how this state tempers her state of mind, she says she is going to give up training. She thinks she "can't be a nurse." Everything seems hard. Lessons grow impossible. The duties as a whole of the training school are exaggerated to drudgery. She "gives up." What a pity

that she cannot learn to relax and to restore herself to a normal point of view!

3. Lack of a strong motive or desire, or, the inability to think of the task in hand as a means to an end. Very often the nurse has to recall her ultimate aim—to become a trained nurse of the finest type. The difficult lesson, the obstreperous bad habit, the trying patient, can all be dealt with in a different spirit if the nurse will only consider how small they are, after all, in comparison with the final gain.

4. The natural fluctuation of interest after the "newness wears off." Interest is keen-edged when curiosity is first being gratified. Ann Sherman is enthusiastic in finding out how it will seem to carry herself in a different approved fashion, but soon in the wearisome effort of consciously *making* her muscles do things differently, she experiences something of "plodding effort." It is always interesting to look into a new book—to try out a subject. It is not long before the textbook is put beside others, long stripped of the glamour of newness. Anatomy, so attractive in its fresh blue cover, on that first book-buying day, becomes dog-eared and "horrid."

5. Distractions and interferences. Other things have a way of appearing so much more beguiling and colourful than the thing in hand. The nurse, looking over the list of habits which she is going to form, feels that she would like to switch to one she hasn't tried, rather than wrestle with the one

in formation. The untried habit would be easier, she thinks, or at any rate more interesting. Frances Tracy in plateau moments wonders whether she wouldn't find some other work more interesting. Her glimpse of the bohemian life of an artist friend lures her. She allows herself to be distracted by imagining herself in such an environment.

6. Lack of ability to concentrate. In mastering a habit, learning a new subject, it is impossible to avoid a very wavy and much plateau-ed practice curve if one has not acquired the habit of concentration. The rather neutral nurse who accepts her subjects and necessary list of habits as a matter of course without much comment and sets quietly and evenly to work, often forges ahead faster than the nurse who "loves" her training one week and "loathes" it the next.

7. Confusion brought about by lack of orderly adjustment of the new ideas. If the nurse is not prepared for a subject, for example,—if she has not the proper preliminary education, she will not be able to take in the new without confusion and perplexity on many points. If she sees other girls mastering the steps of progress without difficulty she is easily overcome by a sense of futility. "It's no use trying"—this is always equivalent to announcing the plateau stage.

Recognizing a plateau as such and determining the reason for it, will help the nurse to get back to a normal state again. Sometimes talking things over with someone who will understand, proves a

sort of support in groping one's way back to uniform effort. Keeping in mind a picture of a steady upward sweep, a curve of progress unbroken by plateaus, will stimulate the nurse to less spasmodic effort. She will not attempt too much in her first enthusiasm, lest she cannot sustain her effort. Sometimes the thud of losing progress takes away an interest in a subject. In setting up new habits she will take the warning of psychologists and not try to form too many habits at one time. Indeed, until one has had practice in forming habits, it is futile to try establishing more than one at a time. Thorough establishment of each new habit in turn, leads to increased ease in "keeping the whip-hand." Only he who is trained to running can run swiftly and surely. Too much haste causes many a tumble to a plateau.

"The great thing in all education is to make our nervous system our ally instead of our enemy"—William James puts the warning aptly. How relentlessly the nervous system may work to the downfall of a human being if it sets up habits of the wrong kind! A woman loses her beauty oftener from unlovely facial habits than from any other cause. The contractions of her facial muscles brought about by the wrong kind of thoughts and feelings, broaden muscles which vulgarize her face and draw ugly lines. A man fails in the big effort of his life for success, because he has never learned to inhibit his bullying instinct. A patient, nursed back to life, falls again into the bad habits

of living which bring him again to his bed. So it goes,—the mercilessness of habit is everywhere, constantly bringing about some sort of loss. The nurse needs to be on guard, lest in her own professional endeavour, her nervous system is her enemy. Habit, which takes care of the routine of her nursing very soon, distinguishes her as a good nurse, an unreliable nurse, a slow nurse, a clumsy nurse, an expert nurse as the case may be.

*The Habits of Patients.*—While the nurse may count, with a degree of certainty upon the manifestations of certain instincts in her patients, she readily learns that the differences of habits are unending. As already pointed out, during illness instincts have the upper hand as a rule. However, habits brought about by certain modifications of instincts, are not wiped out even by disease. Certain it is, that the nurse who will, may learn by studying the habitual expression to read her patient's character to a helpful degree. The habit of years of thinking and feeling in certain ways leaves its stamp upon the face too indelibly to be erased even by dire sickness. The nurse, who needs to study everything about her patient, will not neglect a careful scrutiny of "habit marks" upon the face and body. The young nurse is always told that when she admits a patient she must take careful note of any "peculiarities." Many of these so-called peculiarities are the result of easily recognized habits—the marks of the hypodermic needle in the flesh, a drug habit, the char-

acteristically stained finger-tips, excessive cigarette smoking, the calloused hands, manual work. Constantly the nurse sees examples of disease brought on by wrong habits of bodily posture. The human form, as the nurse sees it, reveals the pitiless marks of indolent physical habits. Block-like men and women of middle-age, with undisciplined bodies set in the vice of undesirable habit, are everywhere. So much of the unloveliness of old age could be obviated if habit had been "made an ally." Where now and then one sees a fine upright old man or woman without a prominent waist-band, such types would be the rule. Why not the general characteristics of suppleness and grace? Must we believe that much as the human race desires to look at least passably well in the eyes of others, that indolence is stronger?

During sickness, there often occur experiences which completely revolutionize an individual's outlook upon life. Such times are opportune for the starting of new habits, radically different from the old. If a man who is a keen lover of living, has faced death because of his indulgence in intoxicants, he will have a strong motive for a new system of living. However, if he does not *know how* to build up a different habit systematically he usually returns to his old ways. Many times the nurse has need to instruct a patient in the laws of habit. In social service work, practical help in making the desired reactions habitual is the great need.

*Points to be observed in helping patients to form habits.*

1. *Use language that is easily understood by the patient.* It is necessary to make the patient understand thoroughly what the laws of habit-formation are. It is not enough to repeat to him the rules as the nurse may know them from her study of psychology. Nor can she have a set way of teaching the rules. She must judge how each patient can best take in the idea of habit building. Her ingenuity may be taxed at times particularly when she is dealing with a patient who has a very limited vocabulary. Sometimes everyday figures of speech will help the patient to catch the meaning. It would be ridiculous of course to use the word "focalization" to Pierre La Vaque who has never heard the word. He must be made to understand focalization in the short simple words of English which he knows. With all patients, whatever their education may be, it is better to avoid the many syllabled words. The sick mind accepts more easily short words and uncomplicated sentence structure. The use of pictures may be very helpful in getting patients to understand what is to be done. Sometimes the patient cannot get a clear idea in any other way of what is to be done. Any child can be made to understand how to alter a bad habit, if the nurse will take him slowly, explaining in words of his world. As an aid in making the plan of progress clear, paper steps may be used. The child, not the nurse, should print

on each step the orderly way in which he must get rid of his bad habit.

2. *Go slow.* Sometimes the nurse who is enthusiastic in helping the patient to form a new habit, proceeds faster with the plan than the patient can follow. Undue rapidity is always a mistake in habit-formation—with the patient, weakened by disease, it is sufficient to discourage him altogether.

3. *Be certain that the patient wants to establish the habit.* It is no use to waste time, trying to help a patient to form a new habit when he has not made up his mind altogether that he wishes to make the effort. It may be a part of the nurse's work to stimulate the patient's initiative—to bring to bear every possible impression that may help. In reconstruction work, when a patient, such as Pierre La Vaque, with artificial limbs, must learn a new occupation, he usually has a strong enough motive for the setting up a new habit of skill—he wants to earn a living. But not always in the desperate patient, bound insidiously to a drug habit, is the motive for the necessary alteration easily established. Sometimes in dealing with a tenement woman brought low by filth, much time is required to bring about a desire on her part for anything different. Hence the value of indirect attack. Impressions which will make the patient build up his own initiative, usually have more effect than direct persuasion. Habits that the patient forms as a result of such a method, usually become

permanent, whereas the habit that is pressed upon a patient seldom lasts long enough to give any result of value,—unless, of course, something happens to crystallize his wavering motive. Pictures, books, comprehending of the ideal condition, have their place in establishing the desired attitude of mind.

A patient, who would not for a long time put forth the effort necessary to walk again, because he "knew he couldn't," became eager to try after looking over some pictures of himself on a camping trip.

"If I could climb and swim like that again—" he cried, "it's worth trying for——"

4. *See that the patient is not hindered by his surroundings.* If a patient is by himself he can concentrate better upon the first necessary steps. Later, it may be well for him to compare his progress with that of other patients, but this should not be allowed until he is far enough along so that he will not be discouraged by greater mastery of others. If the patient is merely trying to form the habit of complete relaxation and rest after eating, he needs to be free from unnecessary distraction. It is possible, even in a busy ward, to give a patient enough isolation by means of screens. The habit of sleep, lost to the patient suffering from insomnia, cannot be regained unless every possible aid is given by means of darkness and quiet, or whatever is needed particularly to soothe.

5. *Avoid, if possible, any unpleasantness at the*

*beginning.* Do not let the habit loom too formidably as a task-master.

6. *In health, one needs stimulation to make his best effort; in sickness the patient cannot get on without it.* It is as if another will must supplement his own. Encouragement should be dealt without stint to the patient. The nurse should never become too much absorbed to forget the needed word. If one can give praise so much the better.

7. *Help him to look out for the temptations and difficulties naturally to be expected.* Make him feel that his difficulties will not be met alone. The nurse can give the patient a very comforting feeling by the mere use of the pronoun "we" instead of "you." When the distraction, the perplexity, the discouragement comes "we shall be ready for it."

8. *Teach the patient to become his own critic.* By expert questioning, recognition of the ideal may be achieved. The nurse, not less than an instructor, needs to study the technique of asking questions. When the patient makes a mistake, or fails to carry out some principle of habit-formation, the nurse avoids saying, "That is not the way to do it —it should be . . . " but, rather, gets the patient to make the desired comparison by asking some such question as, "Is that the way it should be done?" or, "Shall we compare this way with our plan?" Too much stress cannot be laid upon developing the power of self-criticism in the patient. He is sure to make more satisfactory pro-

gress, no matter what kind of habit he is forming. In the beginning the patient must of course be shown what the ideal is, but once he is thoroughly acquainted with it, he should be induced to make his own comparisons.

9. *Remember that the patient is easily fatigued.* Not always does a patient know when he is beginning to get tired. He often "gives out all at once." The nurse needs to watch very closely when the patient is putting forth a new endeavour, lest he exert himself beyond his strength. It is a safe rule to make the steps of progress short enough so that the patient is left with a zest for the thing in hand and at the same time feels no fatigue. Physical weariness will often destroy the patient's interest. The concentration of habit-formation is difficult even for a person in health—the patient has only a limited power of concentration.

10. *Help the patient to "stick to it" by means of a wager, a pledge.* Something of the sort may make him carry out his plan in order to save his self-respect.

11. *Give special attention to avoiding plateaus.* The average patient's curve of progress is full of plateaus. His own understanding of the phenomena will be of use in avoiding the discouragement so characteristic of the sick.

The nurse will readily recognize the danger of becoming "set" in habit, of being a professional marionette. As soon as the nurse loses her ability to form new habits, she begins to be like a machine.

If the sub-conscious self is trained to take orders habit can never become master. Old habits may be dutiful servants. As constantly pointed out by psychologists, people are inclined, as they grow older, to avoid forming new habits, to alter the usual routine. The nurse who has so much to stimulate her to new interests, should keep her responses keen. The dullest of all dull people are those who "aren't interested" merely because it is too much of an exertion on their part to progress any further. Youth, to which we cling, is so easily held to the end of life, if we only keep up *the habit of new habits.* Evolution, the watch-word of youth, means altering habit at will. Flexibility need never be lost.

One of the reasons why old patients are often so hard to deal with is because of their inflexibility. When they fall ill it is a terrible wrench for them to give up the daily routine of their lives. They cannot change the habits of having a bath at a certain time, of eating a particular thing for breakfast. Some people are made very unhappy by travelling experiences, because the new surroundings necessitate another routine. The nurse will measure very carefully the degree of flexibility in her patients, and decide accordingly upon methods of approach and management.

### Definitions

"*Habits.*—Tendencies to respond which are created in whole or in part by experience, practice, or training

are called *Habits*. The instinctive tendencies become habits as soon as experience alters them. Practically all of human behaviour is a series of illustrations of habits. In common talk the word is used only of tendencies to respond which have become very frequent and very habitual, such as eating three meals a day, taking off our clothes when we go to bed, bowing to acquaintances . . . and the like. But the essential nature of the behaviour is the same whether the habit is partially formed and rarely used or fully formed and always used. Indeed, for psychology every tendency for anything to go with anything else is either a case of a pure instinct or of habit." (E. L. Thorndike, *Elements of Psychology*, p. 16.)

## Questions for Study

1. What is the difference between instinct and habit?
2. Why is it easier for some people to form habits than others?
3. Why is it important to realize the difference between the habit that is understood and the habit that is not understood?
4. What steps are to be taken in altering a bad habit? Is forming a new habit any different from altering an old and undesirable habit?
5. Which steps in habit formation are the most difficult?
6. Select a bad habit to be altered. Indicate in detail all the ill effects of the bad habit; state in what way the muscles would act under the new control.

7. What is the cause of plateaus? At what periods of a nurse's training is she prone to succumb to plateaus? Can you recall a plateau experience in your childhood? To what do you think it was due? How may you help yourself to avoid plateaus?

8. What is the value of intensive effort?

9. What desirable habits may each of our five nurses transfer to their training. What bad habits does each nurse need to alter in order to become the highest type of nurse?

10. Which of our five nurses will find it most difficult to form new habits? Why?

11. What does "keeping young" mean? Do you know any one over fifty who has the habit of making new habits?

12. How many new habits have you formed in the last year?

13. What is the use of habit?

14. Make a list of habits which a nurse needs to establish early in her training.

15. How may you recognize mental rigidity in yourself?

16. Describe a face you have studied for habit marks and tell specifically what is expressed and how it is expressed.

17. What points are to be observed in helping a patient to form a habit?

18. Designate a habit to be formed by Mrs. O'Brien and state how you would explain to her the steps to be taken in habit formation. Use direct address, in order that you may have practice in choosing suitable words.

19. What must Isabel Terry do to establish the habit of truthfulness? Why will fixing her attention

upon true detail help? How may she still tell her stories well, without sacrifice of the truth?

20. Mary Anderson is impatient of form. What must she do to train herself to observe hospital etiquette in a graceful way?

21. What happens to a girl of Bessie McCaskell's type who is slow and timid in her practical work, when she sees other nurses out-stripping her in technique?

## References

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James, William. *Psychology,* Chapter 10.

## Questions for Re-education

1. What habits have I that led me to believe I could become a nurse? What habits were the reason for any discouragement I had from others concerning my plan to enter the training school?

2. What habits necessary for the nurse's training may I transfer to my life in general to an advantage?

3. Have I the power of seeing the effects of my bad habits upon others?

4. Why is habit building an education in itself to me?

5. Am I thorough in going into the details concerning the effects of bad habits? And do I study systematically the new way of doing before I attempt it?

6. What habits have my hands that ought to be altered? My feet? My eyes? My mouth? My nose?

7. Do I walk correctly?

8. Draw a picture of myself as I sit at the dining-table. Is the line of my back as it should be? Do I know how to sit? To rise?

9. Do I encounter the plateau stage more often than my companions?

10. Do I lack flexibility in taking on new habits?

11. Have I ever put forth the greatest effort of which I am capable? Was there any unusual result?

12. What bodily habits have I that menace my good health?

13. What bad habits in others affect me most unpleasantly? What is the reason for my special aversion?

14. What do I want to be like when I am old?

15. How do I hold my head? Is there any rigidity of my neck muscles?

16. Is any part of my body hampered because another part is not well trained? Do my back muscles suffer because I do not put my feet down correctly?

17. How do I pick up things? Are my muscles trained to relaxation before taking hold?

18. Do I know anything of the technique of asking questions?

The following points as noted by F. Matthias Alexander in *Man's Supreme Inheritance* are given here in abbreviated form for the convenience of the nurse:

" . . . The correct standing position and the position of mechanical advantage.—I think the average man is very apt to forget that he can not assume a position of stable equilibrium and a position which ensures perfect mobility, unless his feet are so placed

as to furnish at once a stable pose and a ready pivot and fulcrum. The most perfect base is obtained by setting the feet at an angle of about forty-five degrees to one another. In all other erect positions (the defects becoming exaggerated as this angle is decreased), it will be found that there is a tendency to hollow and shorten the back and to protrude the stomach and if any effort is made to avoid these serious faults in posture, such effort will only result—unless the feet are moved to a correct position—in a stiffened, uneasy, and unstable attitude. . . . The narrowing and arching of the back is exactly opposite to what is required by nature, and to that which is obtained in re-education, co-ordination, and re-adjustment, viz., *widening of the back and a more normal and extended position of the spine.* Moreover, if these conditions of the back be first secured, the neck and arms will no longer be stiffened and the other faults will be eradicated. . . . The primary principle involved in attaining a correct standing position is the placing of the feet in that position which will ensure their greatest effect as base, pivot, and fulcrum, and thereby throw the limbs and trunk into that pose in which they may be correctly influenced and *aided* by the force of gravity. The weight of the body rests chiefly upon the rear foot, and the hips should be allowed to go back as far as is possible without altering the balance effected by the position of the feet, and without deliberately throwing the body forward. This movement starts at the ankle and affects particularly the joints of the ankles and the hips. When inclining the body forward, there must be no bending of the spine or neck; from the hips upward, the torso must remain unchanged. When the position is assumed, it is fur-

ther necessary for each person to bring about the proper lengthening of the spine and the adequate widening of the back.

"This standing position is—physiologically correct as a primary factor in the act of walking. The weight is thrown largely upon the rear foot, and thus enables the other knee to be bent and the forward foot to be lifted; at the same time the ankle of the rear foot should be bent so that the whole body is inclined forward thus allowing the propelling force of gravitation to be brought into play."

Further details as suggested by Mr. Alexander are, in brief:

1. Correct walking *lightens* the pressure of the body upon the earth.
2. There is no strain, no tension, no rigidity of movement.
3. The body *lengthens* ever so slightly with each step.
4. The weight of the body is thrown forward evenly.
5. Press ever so lightly *away* from the earth.
6. There is no spring, but a lightness and freedom, a lissome movement.
7. Walk without bending the knees too much.
8. The ball of the foot touches the ground first, but the rest of the foot follows so that there is scarcely a perceptible difference.
9. Employ no muscles of the body unnecessarily, —such as thrusting the head forward or back, or to one side, which makes a tension of the back and the neck muscles.

10. The head is poised naturally and easily without tension.

11. The length of the step should be gauged properly, according to the length of the leg.

12. The hips and shoulders are correctly poised so that there is no wrong pressure, no dropping of the viscera, etc.

Let the nurse study the walks of others and note those who move with ease and grace. Most people walk badly. We have only to stand at the window and watch people go by to be convinced of this. How many people are a joy to watch as they walk down the street? They seem to be pounding into the ground with awkward shifts, tense unnecessary movements.

Let the nurse notice whether in sitting, she throws back her head and stiffens her neck. Following her own movements, with Mr. Alexander's directions as a guide will be helpful:

"Firstly, then, rid the mind of the idea of sitting down, and consider the exercise and each order independently of the final consequences they entail.

"Secondly, stand in the position already described as the correct standing position, with the back of the legs almost touching the seat of the chair.

"Thirdly, order the neck to relax, and at the same time order the head *forward* and up. (Note that to 'order' the muscles of the neck to relax does not mean 'allow the head to fall forward on the chest.' The order suggested is merely a mental preventive to the erroneous preconceived idea.)

"Fourthly, keep clearly in the mind the general idea of the lengthening of the body which is a direct consequence of the third series of orders.

"Fifthly, order simultaneously the hips to move backwards and the knees to bend, the knees and hip-joints acting as hinges. During this act a mental order must be given to widen the back. When this order is filled the experimenter will find himself sitting in the chair. But he is not yet upright, for the body will be inclined forward, unless he frustrates the whole performance at this point by giving his old orders to come to an upright position.

"Sixthly, then, and this is of great importance, pause for an instant in the position in which you will fall into the chair if the earlier instructions have been correctly followed, and then after ordering the neck to relax and the head forward, and up, the spine to lengthen and the back to widen, come back into the chair and to the upright position by using the hips as a hinge, and without shortening the back, stiffening the neck or throwing up the head.

"The act of rising is merely the reversal of the foregoing. Draw the feet back so that one is slightly under the chair, allow the body to move forward from the hips, always keeping in mind the freedom of the neck, and the idea of lengthening the spine. Let the whole body come forward until the centre of gravity falls over the feet, that is to say, until the poise is such that if the chair were removed at this point, you would be left balanced in the position of a person performing the 'frog dance,' then by the exercise of the muscles of the legs and back, straighten the legs at the hips, knees, and ankles, until the erect position is perfectly attained."

# CHAPTER VI

## SENSATION AND ITS MEANING

. . . It is not less sensation we want, but more. The ennobling difference between one man and another—is precisely this that one feels more than another. If we were sponges, perhaps sensation might not be easily got for us; if we were earthworms, liable at every instant to be cut into by the spade, perhaps too much sensation might not be good for us. But being human creatures, *it is good* for us; nay, we are only human in so far as we are sensitive. . . .—JOHN RUSKIN.

NOTE.—Before taking up the study of sensation, it is essential that the nurse should make a careful review of the nervous system, the internal and external senses. The following references will be helpful: Kimber's *Anatomy*, Chapters 19 and 20; Pillsbury's *Essentials of Psychology*, Chapters 2, 3, and 4; Colvin and Bagley's *Human Behaviour*, Chapter 12; William James, *Psychology*, Chapters 2, 3, 4, 5, and 6.

CAN you remember the exact time when you first possessed the discrimination to say, "There isn't any salt on my potato," or "The smell of violets is in the air," or, "The lake is bluer today than it was

yesterday"? As we study our individual growth we readily understand that our senses develop, not by learning first one thing and then another, but by definiteness growing out of vagueness. Sense development is a gradual process, dependent upon training for certain finenesses. For example:

You once knew only that one colour was brighter than another. Soon you learned to tell a red dress from a blue one, a green book from a brown one. You grew to distinguish the colours of the rainbow. You were able to match colours, to recognize variations in shade. You understood the meaning of "complementary colours." You named a certain colour as your favourite. Not on any one day did you make your selection of this "favourite colour." Your preference grew out of one colour experience after another. Certain combinations of colour thereafter became more pleasing to you than others. . . . Colour development may not go much beyond this. If you study to become an interior decorator, a landscape gardener, a designer, an artist, your colour sensations will become much more complicated. You will be sensitive to gradations of hue, to effects which the untrained eye does not see at all. You will learn how to make these gradations, these effects. Colour production will have a special significance for you. Training makes this difference in the ability to interpret and to use colour. So too, education makes the difference between the ear trained to appreciate music and the ear that can

scarcely distinguish tone from noise. With the rest of the senses it is the same.

Mr. Thorndike's statement, "The function of the sensations is to lead us to act properly toward the outside world," strikes their practical value. Certainly, we cannot "act properly" if our senses are blunt and untrained. It is impossible for us to attain the sensitiveness which keeps us in sympathetic touch with the world about us, unless we begin primarily with the training of the senses, following with the study of the meaning of sensation, or perception. The various classifications of the senses are of value, according to the actual aid we get from them in understanding ourselves and the world in which we move.

## I. Visual Sensations

*The Nurse's Sense of Sight.*—It is well known that the sense of sight has the power to leave a deeper impression upon the mind than any other of the five senses. Sight, designated generally as the most important sense to everyone, has for the nurse a special service to perform. Given a normal vision, the nurse should spare no effort to train her eyes to do remarkably well, the work required of them in the care of the sick.

The trained eye is quick as lightning. When a nurse goes into a room, she should be able to take in, not only the general characteristics which give the room its "atmosphere," but the significant

details which tell what has just been going on. Upon entering a sick-room, her glance is directed first of all to the patient. Much depends upon the sureness of her eye. Many hospital charts are histories of inaccurate observations of nurses who have not trained themselves to take in things quickly and exactly. Such nurses often excuse themselves by saying that they were "in a hurry and didn't notice." If the patient has his eyes closed how often the nurse records "Resting," without the least notice of the tell-tale tenseness of the little muscles about the eyes and mouth. Important changes are not always heralded by startling warnings. It is a fact, well known in every hospital, that symptoms of great importance are often overlooked entirely, because they are "such little things."

During the recent epidemic of influenza, a graduate nurse, whose unprofessional charting became a laughing-stock, recorded of her patient, "Sleeping, but I don't like the way he looks." This was crude but effectual nevertheless. The physician was roused to a closer scrutiny of his patient in time to meet carefully an unexpected complication. To observe accurately, and to express her observations in exact professional phrasing should be the nurse's aim. Many a nurse looks at her patient without really seeing him, so to speak. The perfectly trained eye is sensitive to every fluctuation of colour, every shade of expression. The nurse knows when her patient's mouth "tastes

bad" and is quick with a refreshing mouth-wash before he asks for it. She sees that his lips are dry and brings the ointment necessary, before cracks appear. Her eyes assist her in doing much preventive work. . . . The little scowl that means too much light—this does not escape the nurse. Down go the shades without a word from the patient. Many uncomfortable things—even tragedies—may be obviated in the sick-room by the nurse's quickness of observation. Suicidal tendencies of a patient were betrayed by a nurse's observation that, in her absence a screen had been raised a trifle. There was nothing else to tell that the patient had been out of bed against orders, investigating, planning.

When receiving the patient in the hospital, attending him at the clinic, or visiting him in his home, the alert nurse can learn a great deal which is not stated upon the patient's history card or verbal account. The nurse becomes a Sherlock Holmes. She reads stories in hats and stockings—histories in the habit lines of the face. Nothing adds so much to the ability of the public health nurse or the social service worker to get in touch with varied patients, as the training to take a rapid inventory of surroundings and to interpret correctly the significance of details. Surely the fascination of reading life by putting two and two together in this fashion is worth the training of sight to do its preliminary part.

To understand quickly the mood of a patient or

of any one with whom the nurse comes in contact, is invaluable to her in establishing harmonious relationships. The study of the eye, the seat of vision, helps tremendously in getting in touch with people. It is not the eye itself, Alice Meynell states in her delightful essay upon "Eyes," but the eyelids and the eyebrows that betray moods and emotions. The lifting of an eyebrow, the narrowing of an eyelid—how much such trifles mean! The individual who has trained himself not to show his feelings by his facial expression, maintains control of all except the tiny muscles about the eyes. There may be only the slightest contraction, but it betrays, despite his outward show of neutrality, his withdrawal from another point of view.

The nurse learns how to study the eyes closely for significant symptoms. She is impressed by the variety of conditions which may be indicated by the eyes.[1]

*The Patient's Sense of Sight.*—From the standpoint of the patient, let the nurse remember the following points that have to do with the sense of sight:

1. A patient takes in an idea more quickly by sight than by explanation. A very sick patient will often find it too great an exertion to ask questions or to talk. He learns what he can by his sense of sight. . . . At most, the sick usually retain a small amount of detail in their minds, but

[1] Maxwell and Pope, *Practical Nursing*, p. 210.

they can remember more of things they see than things enumerated to them.

2. The average patient sees far more than the nurse may realize. To be sure, patients are often in such a state that they are oblivious the greater part of the time to what is going on about them, but even very sick patients are sometimes startlingly alert by fits and starts. The appearance of the room, significant details are often taken into account when the nurse is unaware of the patient's observation.

"I was so grateful to you for caring for my flowers so nicely. I was too sick to say anything, but I noticed how artistically you always arranged them and gave them fresh water." This remark of a convalescent patient to her nurse is significant.

3. As to the appearance of trays, let the nurse never assume that the patient is too sick to take any notice. A tray cover none too clean, unpolished silver, unattractive dishes, piled with food,—such things combine to make the patient push away his nourishment and refuse to make the effort to eat.

4. Patients watch the faces of doctors and nurses. On guard usually as to speech, the facial expression is sometimes uncontrolled. "The professional mask" is of one's own making. Very useful it is in keeping from the patient that which would only alarm or confuse him. The nurse need not betray by her expression that the patient

is in danger. After a critical hemorrhage, a patient remarked,

"My nurse looked and acted just the same. I didn't know that anything dangerous was happening. I should have died of fright if I had guessed the truth."

At such a crisis it is vitally important that the patient remain calm and it means a great deal to his welfare if the nurse, by her unruffled appearance, can prevent agitation.

There is a time to smile. It annoys some patients to see their nurses too cheerful. The unvarying smiling countenance may grow tiresome. Better no smile at all than the meaningless mechanical stretching of the lips that some nurses term "a professional smile." One may maintain a sympathetic, pleasant expression without smiling.

5. When a convalescent begins to get about again, he is always tired more quickly if he looks at many rapidly moving objects. His vision cannot readjust itself to many changes without great strain. Therefore he should not be allowed to sit at first at a window where he can see too much activity, or to drive in crowded streets.

6. Much has been written upon the psychological effect of colour. It is an important subject for the nurse. She does well to remember that the warm greys, the pastel greens are the most restful hues; buff, particularly enlivening and cheering; red, too long endured decidedly irritating; pink, after a short time, tiresome; lavender

and purples, depressing. The white of hospital walls is no longer in favor because it is too glaring. If it is necessary to have a patient in a room with white walls, the effect should be softened as much as possible, by proper window shades. In considering the sick-room, the old physicians of Greece specified that "the walls should be smooth and of a monotone in colour."[1]

7. No picture should remain on the wall during a long illness, unless there is some special attachment on the part of the patient. Pictures may be used during convalescence and changed with good results from time to time. As recognized in the first century, pictures often disturb patients in delirium. They may even attempt to get out of bed to snatch them.

8. How the patient uses his sense of sight during convalescence should be the deep concern of the nurse.

Nurses are learning that the convalescent period calls for something more than attention to the physical needs. The mind must be drawn back to health. The discriminating nurse recognizes the effect of the body upon the mind as well as the effect of the mind upon the body. . . . One of the chief problems during convalescence is how to entertain the patient during the short time that he is not resting. Entertainment appealing to the constructive instinct is never undertaken the first thing, because the patient is too weak. Usually,

[1] Nutting and Dock, *History of Nursing*, p. 80.

he wants "something to look at." The time is past when the nurse puts into her patient's hands the magazine or the book that is nearest at hand. As a rule, patients should look at pictures before they are allowed to read. Pictures are less fatiguing, since impressions are more direct. What kind of pictures shall the patient have? This is the nurse's particular problem, to be decided according to her patient's temperament, his mood, his need. If it is desirable to rid the patient's mind of an unhealthy idea by wedging in a new quickening interest, this replacement may be accomplished by the simple method of putting into the patient's hands, pictures suggesting the trend of thought desired. Often the mind has to be cleared of morbidness, which, like fungi, destroys wholesome growth. Scrap-books of pictures, each with a special motif, may be used with good effect. Such books are delightful to plan. When you see anything that fits in with an idea you have for a scrap-book, put it aside in a big envelope, labelled with your subject. The making is easy.[1] The selection of titles calls for ingenuity, since much may be gained by the hint contained in a few apt words. The choice of such books for particular patients is absorbing and gratifying in its results. Suppose, for example, a patient is in a deplorable state of melancholy, his mind fixed in selfish grief, upon the loss of his son. Put into his hands a scrap-book

[1] See Appendix, How to Make Occupational Therapy Scrap-books.

containing pictures of all kinds of people. The title "Folks" gives the suggestion that the pictures are not to be regarded just as pictures of people. The patient is reminded that the world is full of a great many kinds of human beings, some of them with troubles that may be helped. This is the beginning wedge. In time possibly the patient's settled melancholy may be displaced by the desire to help others. The patient develops the idea that a human being counts in life only in so far as he is able to serve.

It is naturally too much to presume that looking at one scrap-book with a particular motif will create a new philosophy, but experiments have proved the helpfulness of such impressions toward a desired end. There is no limit to the motifs that may be utilized.

A patient who needed a hobby to serve as "a safety valve," to prevent worry and depression, found a beginning interest in nature study from a book of birds with coloured plates, called *Feathered Friends* and one on flowers under the title, *Posies for You*. Another patient, whose mind was centred too much upon his immediate environment, took a lively interest in books of travel pictures, entitled *Let's Go A Journey-ing*, *Little Corners of the Earth*, *Loiter Here*, and *Places and Faces*. His thoughts were drawn away from their accustomed circle with good results. Many other examples of the practical use of such books might be enumerated.

If a patient merely needs to be entertained and

enlivened, the problem of selection is not hard. Such a book as *Do You Like Dogs?* is almost sure to please. *Mothers*, a collection of pictures showing all kinds of mothers from the pig with eleven little piggies to Indian mothers with their papooses on their backs, brings smiles easily. Cartoons have their place here, provided they are free from vulgarity. Care must be taken to choose pictures that are really funny in a wholesome way. It is to be noted that patients usually tire very quickly of labelled humour, therefore the nurse will never show many "funny pictures" at a time. The "comic" newspaper sheet should not be tolerated in the sick-room. There is so much that is genuinely humorous, why allow a makeshift such as "the coloured supplement"? Newspaper cartoons, apropos of some subject of special interest to the patient, often prove diverting. "Fairy Trails," pictures of fancy, make a good tonic for a mind dull with too much of everyday things. One might go on and on—so many collections of pictures are possible.

The patient should never suspect that the pictures are given to him for any particular purpose other than to amuse him. No patient likes to be moulded. If tactfully used, pictures may do more than spoken words to help the patient back to a normal poise of mind.

Selection of reading, if allowed at all, demands great care.

The nurse must not fail to proceed slowly.

There is always danger of giving the patient too much to see. His mind takes in the first pictures eagerly, but his power of attention is weak and easily strained. For this reason, no book should contain more than one or two dozen well-chosen pictures. In the enthusiasm of doing new things in the care of convalescents, the wise nurse never forgets that *what the patient needs most is rest.*

## II. Auditory Sensation

*The Nurse's Use of the Sense of Hearing.*—By closing our eyes and listening to what is going on about us, we get an inkling of how much we never hear when we are using our sense of sight. At times when we wish to concentrate upon a task and all sorts of noises and tones are filling the air, it is advantage to "make ourselves deaf" for the time being. The necessity of perfect quiet is a great hindrance to many workers. How many precious minutes are wasted, getting out of the way of noise! However, the useful ability to shut out at will the sounds of one's surroundings, need to be carefully controlled, lest it lead to a general attitude of "absent-mindedness." For the most part we hear too little. Our sense of hearing may easily be made much more useful in controlling our behaviour.

The music lover is often heard to speak of how much is missed in life by those who "don't care for music." Any one who is uninterested in all

sound loses much pleasure and valuable suggestions for conduct as well. In the woods how much of interest is lost, if one does not hear the undertuning of nature. The nature lover knows every sound of his world—from the companionable hum of the bee, the funny little squeals of the wood creatures, to the crack of the killing frost in the heart of a pine. In the city streets the intricate pattern of sound is fascinating to him who has ears to hear. All noises and tones which make up the sound of the world are fraught with significance.

The good nurse is as alert as an Indian to sound. The gamut of patients' groans, little stirrings and rustlings, sniffs and snufflings, the baby's first in-take of air, the Cheyne-Stokes breathing of the dying—these are only a few significant sounds of the nurse's world.

"You always know just when my visitors begin to make me nervous and you get rid of them post-haste—I don't see how you can always tell."

The nurse smiled quietly at this remark of her grateful patient. How did she know just the moment to shoo the visitors out of the room? She heard the patient begin to scratch his toes against the sheet. . . . The wise nurse makes use of all the information she can get by way of her sense of hearing.

Does the nurse hear the sounds she herself makes? Does she realize how much they tell of her personality? Her footfall—does she know

how to put her foot on the floor properly so that she can walk softly without going on tiptoe? Can she set things down without a thud or a clatter? Can she move without unnecessary noise? Can she execute the movements of walking, sitting, and so on without annoying sounds? The nurse's voice—if only she might realize what an asset a musical well-placed voice is! Let the nurse study her voice and imagine the impression it makes. She must learn first of all whether her voice is properly placed. It is no use to try to make one's voice agreeable unless placement is accomplished, —the preliminary to all else that may add sweetness and softness of tone. . . . Can any one hear comfortably the nasal tone, so insistent in its "scratchiness"? And the "throaty" voice—doesn't it make your own throat ache to listen to it? Sometimes a voice is really well-placed, but the lips do not do their work well and words are blurred. It is irritating to everyone—particularly to a patient, who has no strength to waste in extra words, to ask a person to repeat what he says. When the nurse speaks to the patient, she should stand where he can see her, or at least hear her distinctly. She should never speak as she is leaning over a chart or when she has her back turned. Her enunciation should be clear and distinct, her voice pitched so that, although she speaks softly, her tone carries well. "Speaking in a soft voice" means to many nurses, using a pitch so low that it is an effort to understand them.

*The Patient's Sense of Hearing.*—"I want another nurse," stoutly a big business man came out with his demand.

"But the nurse you have is most competent," the considerate relative tried to remonstrate.

"Yes, but I don't want her any longer—that's flat."

"But why?"

It was sometime before the reason came.

"She sniffs," divulged the patient at last, somewhat shamefacedly.

He was tired of trying to make himself deaf to that sniff. The situation is not unusual. Patients are incredibly disturbed at times over the little habits of those about them. More often than not, patients are sensitive to sound and usually hear a great deal more than the nurse realizes. Often it is too much of an effort to open their eyes. At such times they may hear more than they hear when their eyes are open. It is never safe to assume that the patient is not listening. Nothing should be said in the sick-room which the patient ought not to hear. People often speak of very ordinary things in an undertone with the idea that they are saving the patient disturbance. The patient is often much upset by things he cannot hear.

Noise and loud tones of course are not to be tolerated in the sick-room. The nurse does not wait for her patient to ask her to find where the door is banging. She is equally alert to the little

squeaks of hinges and swishings of curtain which may annoy. Sometimes the patient doesn't seem to hear big sounds—only little things of rasping key. The nurse learns to hear with her patient's ears. She interprets soothingly any sounds which may alarm him. Many a patient is frightened by a sound that is unfamiliar.

In certain diseases, the nurse is aware that the patient suffers from deafness—she will take the precaution in such cases to enunciate with particular clearness.[1] Patients are distressed temporarily by varying degrees of deafness after taking quinine and other drugs.

When patients are able to listen to music, more than ordinary care should be taken in selecting what is best for them to hear. Emotions are easily aroused by music. The patient's weakened condition makes him more than in health susceptible to impressions of this sort. Memories are aroused, longings stirred. The patient does not have normal control of his emotions. Hysteria is often the result of hearing the wrong kind of music. Despondency, restlessness, and other undesirable conditions may likewise result. On the other hand, so great is the healing power of music that it may be an agent in restoring the patient to health. From the history of early nursing in Greece, we learn that "to soothe the nervous the bed was brought near to a fountain. Music was also used to soothe and lull. Melancholics were

[1] Maxwell and Pope, *Practical Nursing*, p. 212.

to hear music and cheerful amusing tales."[1] The depressed were to be aroused by selections of a joyous nature. . . . The work of applying music in the treatment of the wounded was successful in a marked degree during the recent war, particularly in shell-shock cases. A definite system of music-therapy has been worked out, with special "prescriptions" of musical selections for insomnia, neurasthenia, dyspepsia, tuberculosis, incurable diseases. It remains to be seen how far such treatment may be carried with beneficial psycho-physiological results. It is easy to imagine that Shubert's *Serenade* or Raff's *Spinning Maiden* for insomnia might prove effectual, or, *Tales of Hoffmann*, *To a Wild Rose*, helpful in quieting hysteria, as suggested by Miss Isa Maud Ilsen, R. N.; however, these same selections might prove irritating in the extreme if they had been played so often in the patient's past experience that he had grown to dislike hearing them. On the whole, however, the "musical prescriptions" used in the Reconstruction Hospitals are well worth studying. Whatever the nurse's problem of musical selection may be—though it is nothing more than choosing a phonograph record, she should exercise the same care in her decision as in the choice of books and pictures for her patient. She should understand the character of various keys in order to calculate intelligently the prob-

[1] *History of Nursing*, Nutting, M. A., and Dock, L. L., p. 80.

able effects. The following characterization by Grétry, will be of use to the nurse[1]:

| | |
|---|---|
| C Major—noble and frank | C Minor—pathetic |
| D Major—brilliant | D Minor—melancholy |
| E Major—full of fire | E Minor—sad |
| F Major—mixed | F Minor—most pathetic |
| G Major—war-like | G Minor—most pathetic (except F minor) |
| A Major—very brilliant | A Minor—simplest |
| B Major—gay | |

Grétry further calls attention to the fact that "the character of a musical composition is not exclusively determined by the key or scale but quite as much by the time or tempo, modulations, rhythmical construction, employment of different degrees of loudness, and other conditions"—all of which the nurse needs to consider.

Dr. Egbert Guernsey says in *The Medical Times*,

"If every hospital or asylum included in its medical staff a musical director and if every physician and trained nurse understood the nature of the action of music, there is no telling the good that might be accomplished, the lives brightened, and the tangled brains restored to harmony."

## III. Taste or Gustatory Sensation

*The Nurse's Sense of Taste.*—In the study of Materia Medica the nurse finds many allusions to the effect of different drugs upon the taste. She

[1] This characterization was used by Miss Isa Maud Ilsen, formerly Director of Reconstruction Hospital Music American Red Cross.

will always consider in preparing the patient's nourishment whether the medicine he is taking tends to dull or effect the sense of taste in any way. The nurse herself should taste the food she gives her patient in order that she may vouch for its savoury qualities. She should know whether the milk she offers her patient is really fresh, the butter sweet, the tea and coffe of desirable quality. All food, in short, should meet the rigid test of her trained sense of taste. The nurse should know, as the skilled chief knows, the criterion of what is good to eat and to drink. All the delicacies of flavour should be discriminated. As well as knowing how to achieve triumphs of cookery herself, she needs the ability to direct others clearly in preparing invalid cookery. Naturally in the hospital, all matters pertaining to cookery are attended to by those specially trained to do this work, but in private nursing in the home, the nurse will often find that she must either prepare special food for her patient, or direct others in making it properly.

*The Patient's Sense of Taste.*—If the nurse remembers that taste combines with smell, if she understands the part the olfactory nerve-endings play in tasting things, she will never allow her patient to smell a disagreeable medicine if it can be avoided. Medicine with strong odours should be kept covered until the moment they are to be administered. If the patient holds his breath as the medicine is taken into the mouth, most of the

bad taste will be avoided. In particularly sensitive cases, cotton may be placed in the nostrils. Just as one odour may overcome another, a certain taste may disguise another. This fact is useful in administering medicines that are distasteful—for example, castor oil in orange juice; a bit of licorice held for an instant in the mouth before taking Epsom salts.

Since much of what a patient tastes depends upon what he smells, the nurse will not expect him to have a keen relish for food when he has a cold.[1]

A patient, given an eagerly awaited bit of sweet, often fails to get much taste of sweetness because the nurse puts the morsel too far back on the tongue. She forgets that it is on the tip of the tongue that sweet for the most part is perceived. So, even a little thing like telling the patient to take the sweet with the tip of his tongue may save disappointment. If anything sour must be administered, the substance should be put well back upon the tongue, or even given through a tube, since sour is perceived largely upon the sides of the

[1] "Thus when what common sense calls tastes are found to be due largely to stimulation, not of the gustatory nerve-endings in the mouth, but of the olfactory endings in the nose, psychology changes popular usage and reserves the word tastes for the bare sweets, sours, salts, bitters (possibly alkaline and metallic tastes), and classifies the rich savours of food as smell sensations. One can gain experimental evidence of the share of the nose in taste, by testing some friend, who with eyes shut and nose carefully plugged, tries to distinguish raw potato from apple, maple syrup from molasses, soup from salt water." (E. L. Thorndike, *Elements of Psychology.*)

tongue. It is a mistake to put bitter things far back upon the tongue, as this is the very place the taste beakers for bitter are mostly distributed.

The patient who has taken ether more often complains of tasting ether than of smelling it.

Temperature has much to do with how the patient's food tastes to him. Too often the reason something "doesn't taste right" is because it is served lukewarm. It is the nurse's responsibility to see that cold things are served cold and hot things, hot.

The average patient's taste is altered by the effects of his disease or the medicine he takes. Food often "tastes like nothing at all," or "tastes bitter" or "hasn't the right taste." For this reason the patient needs to be encouraged to eat by placing before him food as inviting as possible. Patients appreciate a variety, and attention to this so far as is possible within the prescribed diet, will help more than anything else to stimulate the patient's taste. Little novelties in the way things are served will often make a patient take an added interest in his food. It is a mistake to serve things always in the same dishes, in exactly the same way if it can be avoided.

Unceasing care in keeping the patient's mouth scrupulously clean helps greatly in improving his sense of taste. After a glass of milk it is necessary to rinse the mouth well in order to avoid a general distaste for nourishment later. No thoughtful nurse will use the same kind of mouth-wash all the

time and expect to get the best results. A mouth-wash should be varied, not only to meet the different conditions of the mouth, but to stimulate the sense of taste.

## IV. Olfactory Sensations

*The Nurse's Use of the Sense of Smell.*—Any one who observes cats and dogs is impressed by the fact that the sense of smell is considerably more useful to them than it is to human beings. It is true, as indicated by psychologists, that the practical value of smell is much greater in the so-called lower animals than in man; but is it not a fact that we might well make our noses of more use than they are? The sense of smell seems somewhat slighted in the general consideration of the senses. Our behaviour would be much more intelligent if we took the trouble to train our sense of smell more carefully.[1] Certainly the nurse cannot dispense with the education of this sense. Her sense of smell is of immense practical value to her. She needs a super-nose. If nature hasn't given her a sensitive nose she should lose no time in educating it. While it is true that many people have a keener sense of smell than others, this sensitiveness

[1] "We want more—it isn't light we need, nor yet more pungent smells. What we need is more discrimination and better understanding of the nature and significance of what we smell. . . . The nose . . . does not restrict itself to labour-union hours; and we press so little duty upon it that the organ suffers more from neglect than from overwork." (Ellwood Hendrick, *The Nose and Its Work.*)

can be developed by training if there is no defect to prevent.

A *chef*, famous on the Pacific coast for his recipes and knowledge of delicious cookery, says that every good cook knows how to use his nose. Certain it is, in the careful cookery that the nurse needs to do, the sense of smell may well be utilized. She may calculate the freshness of meat and fruit by the smell. Fruit loses its inviting fragrance very soon after it is picked. Cold-storage fruit has a characteristic odour. The aromas of tea and coffee and wine play no small part in designating their fineness to the discriminating.

The smell of food cooking is not pleasant to the average patient. A tray is much more appetizing if the patient gets the first whiff of food when it is set before him. As nearly as possible, all odours of food in preparation should be kept out of the sick-room. The smell of toast and bacon is particularly penetrating and persistent. It is very difficult to "get the smell out" if it once gets into the sick-room. Never to be forgotten is the fact that food will never taste good to a patient if it has an unpleasant odour. Burnt toast would not taste particularly bad if it could not be smelled, but even a suggestion of "burnedness" is sufficient to make the patient hate his food. Food must "smell good" to the nurse herself before she offers it to her patient.

When the nurse comes into a room she should notice at once the condition of the air. She should be superlatively sensitive to the significant odours

of the sick-room. Is the air fresh with plenty of oxygen? Is it over-dry? Or too heavy with moisture for the comfort of her patient? Above all, is the air clean and free from the foulness of disease? The trained nose never "gets used to" foul air. Nor will the trained nose accept the smell of antiseptics for cleanliness. It is strange that many nurses after careful training, take no pains to banish the odour of disinfectants. The fact that they may not find them objectionable, does not justify their indifference. To be sure, complete dissipation of such odours is not always possible, but every effort should be made to get rid of them. A pan is not necessarily clean because it is redolent of disinfectants. The effort in the care of nursing equipment should be to allow no smell except that of sweet cleanliness.

The nurse's sense of smell becomes easily "fatigued" by long contact with various odours. Unless she takes particular care, she may not detect in the sick-room what is objectionable to any one coming in from the fresh air. In order to obviate this, the nurse should restore her sense of smell to sensitiveness as often as possible by deep breathing exercises in the fresh air.

Nurses cannot be too careful about changing the clothing completely after the care of ether patients, or after procedures requiring the lavish use of disinfectants. Every nurse knows how quickly the hair becomes redolent of sick-room odours. Frequent shampoos are an absolute

necessity for the nurse, however difficult it may be to arrange them. Loosening the hair and exposing it to the sun helps greatly in keeping it free from objectionable odours. The nurse must not forget that while people as a rule are not sensitive to the things they smell every day—seldom, indeed, giving thought to what they are smelling—their noses quickly become alert to anything that "smells like a hospital." It is in bad taste for the nurse to go on the street, or in company, carrying with her the least suggestion of the sick-room. Not only will the nurse try to keep her own room fresh and unoffending to the most critical sense of smell, but she will endeavour as far as possible to eliminate in her care of the sick, the "hospital odour." Let her think of the hospital as *her* hospital, the private sick-room as *her* sick-room and thus quicken her sensitiveness.

*The Patient's Sense of Smell.*—Perfumes, never in the best taste, are taboo for the nurse, primarily for the patient's sake. The use of perfume to overcome a disagreeable odour creates a nauseating result. Perfume cannot take the place of cleanliness. And why use it if cleanliness exists? Why should the nurse, after her bath, "top off" with a dash of lilac or heliotrope? The nurse cannot hope to escape offending someone by her particular kind of perfume. Even scented powders and soaps are to be avoided.

"Well, how do you like your nurse, Auntie?" inquired the solicitous niece.

"I'd like her better if she didn't use white-rose perfume. I loathe it, you know—oily old Peter always reeked with it," responded Auntie, vigorously fanning to get the objectionable scent out of the room. . . . "Oily old Peter" was responsible for a family scandal. An unfortunate memory probe—the nurse's perfume!

Odours have strong associations—a fact not to be forgotten by the nurse in keeping her patient's mind clear of the past.

Flowers with a strong fragrance affect the patient disagreeably, inducing a feeling of heaviness, a headache or even nausea; yet, people persistently send freesias, tuberoses, hyacinths, and other oppressively sweet flowers to their sick friends. Patients may enjoy a breath or two of such flowers but they should never be left in the sick-room for any length of time. Flowers of all kinds should be removed from the sick-room before night—it is a great mistake to leave them until the last thing before the patient is settled for sleep.

Patients droop like flowers in an atmosphere that is not fresh. Seldom are they themselves aware of the vitiated condition of the air. The nurse must learn to use her nose for her patient.

## V. Dermal Sensations

*The Nurse's Use of Sensations of the Skin.*—Sense-organs of the skin have much to do with our re-

sponses. The nurse, like the surgeon, needs "eyes in the fingers." The nurse gets all manner of information by way of touch. It is useful to be sure of one's hands in an emergency, particularly when they must act as guides in darkness or half-light. To gauge accurately the amount of pressure necessary in various nursing procedures is fundamental in good technic.

*The Patient's Skin Sensations.*—The patient's skin is usually more sensitive than the nurse's own to changes of hot and cold. The nurse, caring for the comfort of her patient, will take infinite pains to have the bath water "just right." Water too hot affects the patient as unpleasantly as cold. The bath thermometer is essential, but the nurse's own sense of touch is needed as well. Most important is the consideration of the patient's circulation, his age, his disease. Patients often dread the end of a bath, because the nurse is careless about replenishing the hot water. The *gradual* application of both heat and cold is to be marked. The nurse soon learns that fomentations borne comfortably by one patient will burn another. Warming the bed linen before changing the bed, protecting the bed from the slightest draught, renewing the hot-water bottles before they become lukewarm,—these little things have a great deal to do with the patient's comfort. The patient's bed should be made up so that at least one thickness of blanket may be tucked about the shoulders. Ether beds should be made up invariably with a

sheet pinned across the back of the bed. Even a slight current of air is dangerous to the patient recovering from an anæsthetic. It is possible to have fresh air in the room without creating a draught, but it is a matter to be most carefully arranged. The nurse should train herself to note the slightest currents and changes of air. At night when the patient's vitality is low, the nurse needs to be more than ever careful to keep him warm and protected from draughts.

## VI. Kinæsthetic Sensations

An understanding of the kinæsthetic sensations, gives us the key to intelligent behaviour as it concerns motion, energy, mass. The nurse is dependent upon her kinæsthetic sensations for accuracy of movement. Her execution of nursing procedures can never be adequate without motor or kinæsthetic training. When a person excuses his clumsy, badly balanced movements by saying that he is "naturally awkward," he indicates that his kinæsthetic sense is defective. An ideal education includes such training from childhood as will establish correct kinæsthesia. If the nurse has not had such training, her problems of re-education and re-adjustment will be many. The weak movements of the patient are made more painful and difficult because of the lack of such training. The nurse will need to keep such a patient from wasting strength by making useless efforts.

## VII. Organic Sensations

The nurse hears a great deal about organic sensations in her work. She is soon aware that the sensations "arising in connection with the activities of the internal organs" are manifold. In her daily charting she is constantly recording these sensations—nausea, thirst, dyspnœa, chilliness, paræsthesia, vertigo, and so on. Organic sensations are closely interwoven with the emotional experiences of both the sick and the well. The nurse needs to keep constant watch of her physical self with reference to her general "feeling" and self-control. Concerning her patient, no one knows better than the nurse, that he is usually engulfed in sensation and "feeling". . . . You have seen at the seaside what the little children call "mouths" or "gobble-'em-ups," which appear to swallow all their neighbours. The nurse so often sees everything of her patient disappear—the thinking, reasoning part of him—"gobbled up" indeed by sensation. If the nurse expects her patient to be more than a bundle of sensations she finds herself unreasonable in her judgment. "How is your patient feeling today?"—a tremendous question, is it not, considered psychologically?

*Intensity of Sensation.*—In considering a person in health, we say that "the intensity of sensation is dependent upon the intensity of the stimulus," but the nurse will remember in dealing with the sick, that intense sensations may be produced by

stimuli accounted mild by herself. Light, which to her is moderately bright, usually appears glaring to the patient. The effect of sudden changes of light is always unpleasant. The shades should never be raised all at once to admit a burst of sunlight. At night, shades or screens should be adjusted *before* the lights are turned on. Water that is comfortable to the nurse may be too cold for the patient's bath. Each patient should be studied carefully in regard to his particular response to stimuli. One patient's intensity of sensation can not be judged by that of another patient.

*Magnetic Forces.*—As pointed out by W. B. Pillsbury, the electric and magnetic forces have no sense-organs and are not recognized as separate qualities. However, the so-called magnetic sense plays so strong a part in nursing that it cannot be disregarded. There is a "wireless connection" between the patient and the nurse. Call it "the sixth sense," a part of "the nursing instinct," "sympathetic understanding"—or what you will, it must be taken into account.

## Definitions

"The word *sensation* is used by writers of psychology with several different meanings. Sometimes they include under this term only feelings of brightness, colour, size, pitch, loudness, timbre or tone-quality, taste, smell, touch, pressure, resistance, movement, heat, cold, pain, position, rotation, hunger, thirst, and other feelings of definite qualities of things and well-

known conditions of the body. But often they include also the feelings of fatigue of different sorts, of effort or strain, of suspense or expectancy, of shock, shuddering, trembling, well-being, malaise, dizziness and other feelings of vague and little-understood bodily conditions.

"Ordinarily they include only the simple, bare, uncombined feelings under the term *sensation* and treat the actual complex feelings (*e. g.*, of the taste of a mouthful of acid, the smell of the woods or the touch of a pin), as mixtures or combinations of simpler elementary feelings. But they also use the word more vaguely for all direct feelings of the qualities of things or of conditions of the body which are not the definite feelings of things classed as precepts or the rich combinations of feelings classed as emotions. This being the usage, the complex sound of a city street, the taste of coffee or the shock of a cold plunge would be called a sensation. Sensations are sometimes defined as the primitive bare elements of mental life, the first things in consciousness. From this point of view only the original appearance of any feeling may be called sensation; after that the mental state equals sensation plus association or experience. . . . Realizing then that definitions must be rough, one may say that sensations are direct feelings of qualities of things or of conditions of the body. Pure sensations are such feelings when uninfluenced by previous experiences. Elementary sensations are such feelings so simple or minute as to be unanalyzable into simpler ones." (E. L. Thorndike, *Elements of Psychology*, p. 20.)

### Questions for Study

1. Why do we rarely experience a single sensation at one time?

2. Give an example of a certain kind of work that calls for special training of the sense of sight; of hearing; of smell; of taste; of touch.

3. What is the advantage of "more sensation" as Ruskin puts it?

4. Which sense has the power to leave a deeper impression upon the mind than any of the other senses?

5. In what ways does the observation of other people's eyes help the nurse?

6. In what specific ways may the nurse's sense of sight be of use to her?

7. Of what use are pictures in the replacement of ideas?

8. What points are to be considered in regard to the patient's sense of sight? His sense of hearing?

9. How may the nurse's sense of hearing help her to give higher service?

10. What medicines affect the hearing?

11. Why is vertigo present in Menière's disease or in suppurative states of the middle ear?

12. What evidences of the nurse's untrained sense of sight have you witnessed? Of an untrained sense of hearing? Of smell? Of taste? Of touch?

13. Why is a patient who has a cold unable to taste things?

14. Upon what part of the tongue is sweet mostly perceived? Sour? Bitter?

15. What are kinæsthetic sensations? How may one establish a normal kinæsthesia?

16. What are organic sensations? Give examples of organic sensations expressed in charting terms.

17. Select from a "While Away" library a book of pictures for each of our five patients. Give your reasons for your selections.

18. Give an example of a patient's sensitiveness to colour.

19. "Which sensations are aroused by distant objects?"

20. "Which sensations are least delusive, most reliable?" (E. L. THORNDIKE, *Elements of Psychology.*)

21. What phonograph records would you select for a patient suffering from insomnia? Melancholy?

22. How does sensation become useful to us?

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## QUESTIONS FOR RE-EDUCATION

1. Which of my "five senses" is most highly trained? Which sense is most in need of training?

2. What blunders have I made which would have been obviated by more careful training of the sense of sight? Of hearing? Of taste? Of smell? Of touch?

3. What pleasures have I missed because of lack of sense training?

4. How may I learn how my own voice sounds?

5. Am I alive to colour? What effect do the colours I select habitually for my dress and room, have upon other people?

6. Have I the will power to undertake the training necessary to gain a normal kinæsthesia?

### Exercises for Sense Training

Education of late years has laid much stress upon sense training of children. It is not so very long ago that little attention was paid to training a child to discriminate between shades of colour, to recognize various pitches and to pick out separate tones, to tell by touch (with the eyes shut) the difference between fabrics, to judge the weight of objects by lifting them, to calculate the measurement of objects without a rule, to distinguish and name odours, to co-ordinate the body properly in making movements. The special exercises devoted to sense training help a great deal in starting a child at an advantage in life. There are many nurses in training and actively at work in the profession today who had no such education in their childhood, nor have they paid much attention to sense training as they reached the age when they might choose for themselves. Naturally, undertaking sense training in a special way after one is twenty, means overcoming a great deal of resistance and undoing many bad habits. After years of response to defective "guiding orders," a struggle is necessary to regain a normal kinæsthesia. However, it can be done. Such an achievement is so well worth while that no nurse should fail to accomplish it. Adequate sense training has its reward in a power of living impos-

sible to attain, even to comprehend, without it. As sense training progresses, the student has revelation upon revelation.

"I never dreamed that I could get so much out of life." This is the triumphant cry of everyone who "stays with it" long enough to get results in sense training.

The nurse who is occupied with a very full schedule, may feel that she has no extra time to devote to exercises for sense training, but such work should be regarded, not as something which *may* be done but as a part of her nursing education which cannot be omitted. It is possible, by utilizing bits of time, to accomplish much.

1. Exercises for developing power of taking in detail rapidly:

(a) As an automobile passes, note the occupants, first paying attention to the sex and type. A second automobile passes. Note the occupants in the same way. Recall the occupants of the first automobile and then repeat those in the second. Proceed in the same way with the occupants of a third, a fourth, a fifth automobile—each time repeating the list from the first. Do not try to hold too long a procession in the mind at first. As your training proceeds make the procession as long as possible. After practice in noting merely the sex and type of the passers-by, add detail. Note the hats, the dominant colours, the marked characteristics to be seen at a glance. In recalling the procession, visualize the passers-by each time.

See them in colour, not in black and white images. At first one can do little more than remember the sex of the passers-by, but very rapidly an amazing power of taking in detail can be developed. This same exercise may be practised as one is walking along the street. Considerable detail is possible, even at a glance. The exercise may be carried on without giving others the impression of being stared at. Only a casual glance is needed. At first you may be able only to recall that you have passed "a big man with a straw hat" or "a little woman wearing glasses," but soon you can take in small details, such as the man's brown gloves, or the woman's checked neck-ribbon.

This has proved a most practical and helpful exercise to those who have tried it. Fortunately, it takes no extra time, since it can be practised any time when one is going about.

(b) Go into a room, allowing yourself fifteen seconds to note the colour of the walls, wood finishing, rugs and curtains. Go into another room and repeat the process. Recall the details of room number one. Practise retaining memory pictures of several rooms in this way. Later add to the detail. Note the character of the furniture, the kind of pictures, any unusual feature which gives individuality to the room. Last may be included the details which suggest what has been going on last in the room.

Many people come and go, making visits in rooms many, many times—yet admit they cannot

remember anything about the furniture or colour schemes. Aside from helping train the mind to take in detail, the exercise just described proves valuable in giving many personality hints.

(c) Sketch some place where you have had a particularly good time. Include as much detail as possible. Follow with a sketch of a place where you had an unusually trying or unpleasant experience. In which picture is there more detail? How do you account for your ability to recall more detail in one sketch than in the other?

2. Exercises for developing colour appreciation.

(a) With water colours reproduce the colour of pictures you have taken while camping or motoring. Only the faintest shades should be attempted at first, otherwise the pictures will look splotchy. Memory pictures hold much more of interest if one is able to recall colours. In looking at a scene, it is helpful to repeat the tones which make up its composition.

(b) Study the original of a painting, trying to fix the colour detail in the mind. Later, without the picture, write a description of the colour detail.

(c) Mix blue and yellow. What colour do you get? Mix other primary colours in order to make the list of spectral colours.

(d) Plan a breakfast room with a cheerful colour scheme. Tell just how you would place the colour.

(e) Plan a living-room with a colour scheme that you think would be pleasant to see every day.

3. In the following quotation from Rupert

Brooke's poem, *The Great Lover*, pick out the things which appeal to the sense of sight, touch, smell, taste, hearing:

"These I have loved:
White plates and cups, clean-gleaming,
Ringed with blue lines; and feathery, færy dust;
Wet roofs, beneath the lamp-light; the strong crust
Of friendly bread; and many-tasting food;
Rainbows; and the blue bitter smoke of wood;
And radiant raindrops couching in cool flowers;
And flowers themselves, that sway through sunny hours,
Dreaming of moths that drink them under the moon;
Then, the cool kindliness of sheets, that soon
Smooth away trouble; and the rough male kiss
Of blankets; grainy wood; live hair that is
Shining and free; blue-massing clouds; the keen
Unpassioned beauty of a great machine;
The benison of hot water; furs to touch;
The good smell of old clothes; and other such—
The comfortable smell of friendly fingers,
Hair's fragrance, and the musty reek that lingers
About dead leaves and last year's ferns. . .
Dear names,
And thousand other throng to me! Royal flames;
Sweet water's dimpling laugh from tap or spring;
Holes in the ground; and voices that do sing;
Voices in laughter, too; and body's pain,
Soon turned to peace, and the deep-panting train;
Firm sands; the little dulling edge of foam
That browns and dwindles as the wave goes home;
And washes stones, gay for an hour; the cold
Graveness of iron: moist black earthen mould;

Sleep; and high places; footprints in the dew;
And oaks; and brown horse-chestnuts, glossy-new;
And new-peeled sticks; and shining pools on grass;—
All these have been my loves."

4. Write a list of the special things you love. From which sense do you get the most enjoyment?

5. To develop attention to little sounds, follow the example of the child at dawn and with your eyes closed, pick out the sounds of the day waking up—or going to sleep:

"When night has gone
I like to lie awake
To hear the little sounds at dawn.
I hear the leaves a-shake
Deciding what to sing.
The birds are practising their scales,
The little blue-bells ring-a-ching
To rouse the sleepy dales.
A frog rolls over in his sleep
And croaks, "I must get up."
I catch the drumming deep
Of bees within a buttercup.
I sit up straight in bed to hark—
I hear a baby humming bird
Exploring in the dark.
Outside the heavy walls
The music sounds so far away—
I hear some steps along the halls,
And then I know it's Day."

6. Listening to one's self read aloud is an excellent way to develop self-criticism as well as to

train the voice to richer expression. Fine shades of meaning brought out by varied inflections should be a part of such practice. It is wise to choose a variety of material for this reading. Plays are good because of the quick changes of interpretation. Naturalness of expression should always be the aim. The unnatural, "stagey" voice which many people adopt the moment they begin to read aloud, should be carefully avoided. A suggested list for reading aloud:

*The Wind in the Willows.* KENNETH GRAHAME.
*The Book of the Little Past.* JOSEPHINE PRESTON PEABODY.
*Lorna Doone.* BLACKMORE.
*Five Tales.*, *Justice.* JOHN GALSWORTHY.
*Half Hours.* J. M. BARRIE.
*Actions and Reactions.*, *Kim.* RUDYARD KIPLING.
*Peacock Pie.* WALTER DE LA MARE.
*The Crescent Moon.* RABINDRANATH TAGORE.
*The Old Wives' Tale.*, *Milestones.* ARNOLD BENNETT.
*The Magnificent Ambersons.* BOOTH TARKINGTON.
*How He Lied to Her Husband.* GEORGE BERNARD SHAW.
*Familiar Studies of Men and Books.*, *Travels with a Donkey.*, *A Child's Garden of Verses.*, *Essays and Letters.* ROBERT LOUIS STEVENSON.
*Life of the Bee.*, *The Betrothal.* MAETERLINCK.

*Jeremy.* HUGH WALPOLE.
*The Four Million.* O. HENRY.
*Round the Red Lamp.* A. CONAN DOYLE.
*The New Poetry, Anthology.* MONROE AND HENDERSON.

7. Try saying "No" with as many varied inflections as possible. Indicate the feeling expressed by each inflection. Try saying "Yes" and "Oh" in the same way. Almost every conceivable emotion may be expressed by a monosyllable. Such practice increases the flexibility of the voice and at the same time, awakens the nurse to the importance of voicing even a monosyllable.

8. Analyze a pattern of sound from the street. What different tones and noises go to make up the melody of sound?

9. Give examples of tones you hear, not coming from musical instruments.

10. "Give the names of two things which seem to you to have somewhat the same kind of smell that the thing named has in the case of each of the following:

| | | |
|---|---|---|
| chloroform | coffee | tobacco |
| camphor | rancid butter | decaying meat |
| cinnamon | roses | new-mown hay |
| alcohol | apples | cheese |
| benzine | onions | bananas |

11. "Prepare four pieces (cubes about one quarter of an inch long) of each of the following:

raw apple, raw onion, raw celery, cooked chicken, cooked beef, cooked lamb; and have ready a half-spoonful each of honey, maple syrup, molasses, cinnamon, clove, and nutmeg, a medicine dropper (a plain glass rod will do), and a salt spoon or a visiting card cut lengthwise into six or seven strips.

"Let the subject of the experiment be seated, with eyes closed and nose carefully plugged with cotton. Say to him, 'I shall put something in your mouth; taste it and tell me what it is before you swallow it.' Require the subject to answer at once before the odour can penetrate to the nose through the passage at the back of the mouth cavity. Then place a piece or drop or pinch of the food, say a pinch of cinnamon, on his tongue and record his answer. Give different substances in a mixed-up order, using each two times and recording the substance and the answer in each case.

"After these twenty-four trials have been made, remove the filling from the subject's nose and repeat the twenty-four trials.

"Compare the number of errors in the two cases. Why would it be desirable to repeat the experiment on another person, testing him first with nose open and later with nose plugged?" (E. L. THORNDIKE, *Elements of Psychology*, p. 34.)

12. Prepare small vessels of water at what you judge by touch to be the various temperatures:

cold.....between 55° and 65°
cool.....between 65° and 75°

temperate.....between 75° and 85°
tepid.....between 85° and 92°
warm.....between 92° and 98°
hot.....between 98° and 112°

After deciding the temperatures by touch, and recording them, use the thermometer and compare.

13. Try to tell by touch, with the eyes closed, the difference between pieces of cotton, velvet, silk, satin, linen, painted wood, varnished wood, leather, linoleum, cork, etc.

14. Practise estimating the size of rugs, dimensions of rooms, length of gauze strips, etc., and compare with the exact measurement by rule.

15. Practise, with eyes blindfolded, selecting beads of graduated size from a bowl of all sorts of beads. String four of the largest, four of the next size and so on, until you have a six-inch length. Practice in design work with the eyes blindfolded trains the fingers to deftness and sureness as nothing else. It is interesting to draw a simple design and to try to work it out in beads, from memory.

16. Place a spoonful of each of the following substances in saucers (labelled underneath):

| | |
|---|---|
| epsom salts | boracic-acid crystals |
| oxalic-acid crystals | potassium bromide |
| sodium chloride | acetanilid |

Ask someone else to move the saucers about and then try to name the substances.

Other exercises for the senses may be found in *Human Behaviour*, Colvin and Bagley; *Elements of Psychology*, E. L. Thorndike; *Essentials of Psychology*, Pillsbury.

## CHAPTER VII

### TAKING THINGS INTO THE MIND

THE slang expressions, "Do you get it?" and "Does it percolate?" are only other ways of saying, "Do you apperceive it?" That is, does your mind attach a meaning to sensation? Does your mind give identity to the object you see, the fragrance you smell? Do you interpret, explain the new by your stock of old ideas? In short, does your mind take in, or adjust the new knowledge by means of what you already know?

William James says that apperception means nothing more than taking a thing into the mind. He says,

"Apperception . . . corresponds to nothing peculiar or elementary in psychology, being only one of the innumerable results of the psychological process of association of ideas . . . The gist of the matter is this: Every sensation that comes in from without, be it a sentence which we hear, an object of vision, or an effluvium which assails our nose, no sooner enters our consciousness than it is drafted off in some determinate direction or other making connection with the other materials al-

ready there, and finally producing what we call our reaction. The particular connections it strikes into are determined by our past experiences and the 'associations' of the present sort of impression with them."

In studying our five nurses, it is apparent that each one takes things into the mind in a different way and that each has a different reaction. As we grow to know them, we understand somewhat of the ideas, memories, interests, desires of each girl. We can speculate how an impression will be received by each mind. It is natural that Mary Anderson, who has learned in her experience upon the ranch, much concerning reproduction, will take in the scientific ideas of eugenics much more readily and naturally than Bessie McCaskell, whose narrow life has shut out such considerations as something unfitting for a young girl to think about. Mary Anderson knows with what care the stock of Triple X is bred. She has helped select the finest seeds from the crops each season, watched the elimination of poor fruit trees, studied grafting and experimented in developing a new type of dahlia from her gorgeous collection of choice specimens. She talks in unembarrassed fashion about the reproduction of human life, while Bessie McCaskell has to undergo a period of awkwardness in expressing herself upon the subject. Frances Tracy grasps readily the fact that a different vocabulary is needed for certain patients and selects her words with more discrimination than

the other four nurses, because she has studied the various types in mining towns. She has had practice in talking about the same thing in a great many different ways, according to the apperceptive bases of her listeners. Ann Sherman picks up any scientific point more easily than her companions, because her previous study has given her a broader preparation for new scientific facts. We may guess rather accurately how each nurse will "take" this and that happening; why one has praise and another antagonism for a new regulation; why one broods when others laugh; why one must have a point explained oftener than any other nurse; why one "sees no harm" in hoodwinking. The student of human nature becomes very keen in surmising what another will say to a request.

Groups of people who receive for a considerable period the same impressions, taking in ideas set forth by one that each accepts as a leader, develop a natural similarity of thought. Each member of the group behaves in a way similar to another member when meeting a new sensation. The apperceptive bases of one resemble the apperceptive bases of another. If the leader calls for action, he may be comparatively sure of a certain oneness of mind controlling his group. We recognize this oneness of group thought when we say that an organization stands against unionism of labour and another for it; or when we say that a certain school is democratic, another school, snobbish. In event of a community need, the

public "knows what to expect" of a particular group of women who have shown by repeated acts of charity and helpfulness an attitude in common. A superintendent of nurses, knowing her training school, expects with confidence that the nurses will respond willingly, bravely, during an epidemic to the emergency call for longer hours on duty. By their whole-hearted service they sustain the ideals which give the school its high character. This similarity of habitual tendencies gives society "atmosphere," communities "tone," and nations a John Bull, an Uncle Sam, characterizing a composite of the national ideas.

The general characterization of the group mind may lead us astray. So thoroughly do we become imbued with the characteristic tendencies of groups that we often show forgetfulness of the fact that the apperceptive bases of each individual differ to a varying degree. We proclaim ourselves insular by clapping such and such a label upon the apperceptive bases of every Englishman, every Eskimo, and so on, calling the roll of peoples by "type." We should not need to travel around the world to discover the simple psychological fact that each human being takes things into his mind in a different way.

To a certain extent, we may understand the apperceptive bases of another mind, but never entirely; at best we may only speculate concerning it. Since a complete inventory of another mind is not possible, we are constantly baffled in trying

to understand people. To a certain extent we may learn the habitual tendencies of other people, the consideration of which is helpful in establishing harmonious relations, but always we must stop short of final hard-set conclusions. Truly, "we are creatures clad in veils," which "man with all his deep communion" has failed to penetrate. What are these veils, except veil after veil of past experiences? The young student of human nature becomes discouraged very frequently by the impenetrability of other people's minds. Human beings seem full of unfathomable mystery. Bessie McCaskell declares that she "can't get at people." Her very quickness in understanding a situation, in comprehending something of others' reactions, leads her to the point where she feels baffled because she cannot understand *everything*. Let us not be discouraged by the fact that we may *not* know all. Rather, let us grow in discretion, tolerance, sympathy. . . . As soon as we learn that each person takes things into his mind differently because of his individual experiences we begin to show a more careful and intelligent approach. Moreover, we develop the good sense to *remember* that meanings are individual. It is one thing to know this and another to keep it constantly in mind in dealing with people. Let us make the most of what we *may* grasp concerning the widely varying apperceptive bases of other people.

We know that every new impression, as soon as

it is taken in, is greeted by a Receiving Committee, self-appointed, from the mind's stock of ideas. There is a stir, a flutter over The New Impression. There is more or less hob-nobbing, according to its importance. Sometimes it upsets everything—again, it creates only the mildest sensation. The Receiving Committee—the group of conceptions meeting, surrounding, assimilating the New Impression—psychologists call the "apperceiving mass." The new impression is "engulfed"—that is, the old meets the new. The old plus the new make an addition to the mental make-up—a "new field of consciousness." The new impression is now at home—one of the family circle of ideas. Fortunate the mind that always knows just how to dispose of the new impression. Blurred ideas, misconceptions result when the receiving ideas cannot adequately and exactly manage the new. The old ideas are not equal to their task of disposing of the new in orderly fashion. Many of the humorous blunders, the discouragements of young nurses occur because there is such a wide gulf between the new and the old experience that they cannot interpret the new correctly. There is not enough in the sum of their past experience to enable them to meet the new without being puzzled and confused. It is important, in view of the many new subjects in the training-school curriculum, that the nurse should have a thorough general education and that she should take in her preliminary course such studies

as will help her to understand the new. Ridiculous mistakes occur when we jump at conclusions, which is only another way of saying that our old stock of ideas has become "mixed up" in identifying the new. An orderly, well-trained stock of ideas then is essential.

Before going further, let us consider the part of us that is out for ideas, the self that looks after the equipment of the mind, the mental buyer. Ideally, we might call this part of us "Light." This equipper of the mind should be regarded as important. There is a fine zest in stocking the mind, in keeping it ever ready and competent to meet the new. We want, naturally, a good stock of ideas, but do we think as much about keeping those ideas in orderly fashion? Does the association-of-ideas contingent always know where things belong? The keeper of the mind should tolerate no clutter. . . . In recognizing this keeper we proclaim ourselves as *choosers* of ideas.

As we proceed with our study of psychology, we realize the fact that every human being is made up of many so-called different selves, each struggling to dominate, each having a hand in moulding the individual, controlling his conduct. Each person is revealed to himself as many personalities in turn." I don't know what made me act like that," we say, recognizing some unbridled power of past experience over our conduct.

In Maurice Maeterlinck's story, *The Betrothal*,

the fairy Berylune gives back to Tyltyl his little green hat with the sapphire in it which makes him see *truth*. We must seek truth whether we are taking in impressions of serums or sunshine. When we fail to see the truth in science, in human beings, in life in general, our minds become a-whirl with confusion. That is what happened to Tyltyl when he turned the sapphire the wrong way:

Tyltyl puts on his hat and turns the sapphire. Forthwith from the earth and from every side little creatures of different sizes appear dressed like him and resembling him in nearly every respect. They surround him, rush against him, hustle him, and try to drag him, some to the right, others to the left, while he struggles in the midst of them without knowing to which he should give his attention.

TYLTYL: (*Distraught.*) Hullo, hullo, what's all this? What does it mean? That sapphire is really becoming impossible!

LIGHT: Don't worry; you'll have turned it the wrong way again. What did you do?

TYLTYL: How can I tell? . . . This is getting too much for me! Too mixed up, really. I must have pressed it instead of turning it.

LIGHT: That's what I thought. You have simply released some of your other "You's".

TYLTYL: (*Dumfounded.*) Some of my other "Me's"?

LIGHT: Yes, what I mean is that you are not alone inside yourself and that . . .

TYLTYL: (*More and more dumfounded.*) I am not alone inside myself?

LIGHT: Why, no, there are a number of other personalities there, more or less like you and all the time trying to get the upper hand.

TYLTYL: No, but really, what else is there inside me? I must be a sort of menagerie or Noah's ark! There's no end to it!

LIGHT: That's true. There would be no end if we had the time to go into it all. . . . But press the sapphire down now and all will be well. (*Tyltyl presses the sapphire and all his Doubles disappear.*)

TYLTYL: My word! A good riddance! . . . Well, as you say, they may be the least bit like me, but some of them are very ugly. Particularly a big, dark one, who kept on tripping me up and very nearly made me fall.

LIGHT: Of course, there are some of all kinds, as in every man. . . . One must learn to choose the best and avoid the worst. . . .

This is a whimsical way of saying that we must learn to marshall our best forces to control our mind.

With the keeper of the mind in control, we attend to taking things into the mind. An inventory of our mind will reveal a great deal of room for new ideas. Our little stock of ideas rattles about very lonesomely in such a vast storehouse. Here we have need of curiosity. The livelier our fine curiosity, the less trouble we shall have about getting new things into the mind, that is, the easier it will be to overcome the natural clannishness of the old ideas.

The *law of economy in apperception* might be

summed up in the saying which is ages old: "Human resistance is universal." When we take in a new impression we try to make it fit in with the old ideas. That receiving committee of ideas tries to associate it with something already in the mind. William James says that we hate anything absolutely new, anything without a name, for which a new name must be forged. He points out that many of the quaint and funny sayings of children illustrate the tendency to take the *nearest* name although it be inappropriate. A child I know said that a waterfall, looked "like a big shampoo." This shows the seeking for relationship of the new to the old. Our stock of ideas is more or less reluctant to welcome anything new, according to the liveliness of our curiosity and the control of the keeper of the mind. People who seldom "have company" are completely upset when the door must be opened to visitors. They do not want change. We naturally set our minds against new impressions, unless we train ourselves to habitual receptivity. We must keep our curiosity alive. The keeper of our mind must never be satisfied with the stock of ideas on hand. Try as we may, we shall never be able to fill that vast storehouse, the mind, but at least we are going to keep on trying. What we take in is an increasing credit to us. Fatal to development is the slightest giving in to the natural resistance of the mind against the new. Often we say we "don't like" a book, a new subject—our minds are only obstinate in letting

in the unaccustomed thoughts. Studies are designated as hard, when our stock of ideas has to work to put two and two together—when there is nothing in our previous training very directly related to the new. We "don't care" for the stranger whose manner and talk puts him entirely out of our realm of experience. If we are clear-headed we learn to label such attitudes by the right name—natural resistance to the new. The instinct of combativeness was given to human beings to use. . . . We need it first and last of all in the lifelong fight to keep our minds receptive, hospitable, eager. The keeper of the mind must have many a combat with the indolent, too self-satisfied old ideas. There must be many a shaking up, many an illuminating analysis of the insidious settling down tendency. As we grow older, the first thing we know we begin to call ourselves conservative—meaning, the truth laid bare, that we are merely becoming smugly content with our old stock of ideas, that we do not *want* anything different. The readjustment that a new impression causes is too much work. It is so much easier to sit by the fire and toast our toes—to be "at home to no one, James." James, if he is a wise and properly combative keeper of the mind, will disregard our injunction no matter what happens. A pretty upheaval there may be—but it is good for us. We are saved from becoming fossils. Let us ask no indulgence of the keeper of the mind. Let it not be said of us, "It's no

use to talk to him—he has his own ideas." Once a habit of alacrity in meeting the new is established, we have won a victory. Re-education involves such training. Very early such training must be begun, lest we actually reach the stage where we find readjustment impossible. To give up to the old—this is the tragedy of life that brings boredom to ourselves and our associates. If we love living indeed, let us conquer our inborn stubbornness to receive the new. Only he who trains himself to ready adjustments of the mind's stock of ideas, "dies young," as Stevenson puts it—"in the hot-fit of life, a-tiptoe on the highest point of being . . . passes at a bound to the other side. The noise of the mallet and chisel is scarcely quenched, the trumpets are hardly done blowing, when, trailing with him clouds of glory, this happy-starred, full-blooded spirit shoots into the spiritual land." . . . Let us train ourselves to youth, while we have the elasticity, the "something spontaneous and pushing" in us that stirs us to combat natural resistance.

In taking things into the mind, we grow in individual power in proportion to our ability to choose, to select what we want to admit. Discrimination gives our mind fineness. Catholicity of interest aids in establishing apperceptive bases of such character that we may obtain a broad sympathetic attitude toward life in general.

Concerning herself the nurse will hold in mind these points:

1. She should keep herself constantly alert, open to new impressions, eager to create new adjustments, to conquer natural resistance. She makes up her mind to "die young."

2. She should take into account the effect of her body upon her mind. Her health has much to do with the way she takes things into her mind. Particularly important is recognition of the effect of the menstrual function upon her mental outlook. (See Appendix, The Nurse's Health.)

3. She does not expect everyone else to think as she does about everything. She avoids argumentative attitudes in conversation. She never tries to make someone else feel that his opinion is wrong or not worth considering simply because it happens not to fit with her own. If it is desirable or necessary to make another person change his attitude, she will never attempt to bring this about by direct attack. Often the mind of another has to take in a great many preliminary ideas, before the change can be brought about. If a person "can't see" a thing, his inability is not always due to stubbornness. He may be deficient in the stock of ideas necessary to take in the new idea. Readjustments of opinion become a matter of education. An intelligent discussion of a matter, the dialogue disclosing trained thought on the part of both persons, becomes a delight. An argument—a deliberate beating down of another's ideas in order to shout "I am right—you are wrong," can never be anything but degrading to

those who engage in it. When the nurse is right and, for the sake of justice, the thing in hand has to be decided, instead of battering at her opposer with "no" and "not" and flat statements contrary to his, she makes her opposer answer some fair questions. If his belligerency does not actually disappear, at least he soon becomes more reasonable. The interrogative method of going over the ground, always clears up a situation more quickly and skilfully than any other way.

4. She should make the right connection between the new and the old—she should "bridge" carefully in order to avoid confusion.

5. She should remember the influence of moods and emotions. She will recognize the necessity of poise as a means of receiving things correctly into the mind.

6. She should never forget that exquisite attention to *detail* is essential in taking in new ideas.

7. She should see that her vocabulary grows to name adequately her new stock of ideas. She will know exactly the technical term to fit her new professional knowledge.

8. She should keep constant guard of her mind lest it lose its receptivity, its eagerness for the new.

Concerning the patient, the nurse considers the points upon apperception among the most helpful in directing her "how to get on."

1. The nurse remembers the apperceptive bases of each person must differ; she regulates her methods of approach accordingly. She does not try

to "make over" her patients. She appreciates the fact that each person is made up of "a bundle of past experiences" peculiarly his own. If her own experience has been so very different, if her apperceptive bases are so foreign to his that she cannot get his point of view, at least she will not term him "queer." Toleration goes hand in hand with sympathy. The nurse respects other people's right to an individual point of view. She does not antagonize by expressing adverse opinions of social, religious, or political ideas different from her own. She develops infinite patience with her patient's whims and peculiarities. She uses her imagination to grasp the particular reaction of impressions in the minds of various patients. Always she remembers that each one is taking things into the mind in a different way. Therefore, one way of dealing with patients is impossible. The nurse gets in touch with a patient, by determining, as far as possible, what his habitual attitudes, his apperceptive bases may be. She studies carefully the many influences causing different responses to the same stimuli. Chief among these influences are:

(1) The differences due to heredity—family and racial tendencies. The nurse learns quickly in caring for Japanese patients that they have a tendency to stoicism and secretiveness, to false perceptions and falsification. She sees in her negro patients much demonstration of fear and superstition. Almost invariably they respond to

rhythm quickly and during convalescence play like children. She finds that the Indian usually sustains his reputation for bearing pain well, without much outward show. Knowledge of the marked characteristics of the various nationalities representing the white race is of some value to the nurse. She expects considerable emotion and a great outcry from the Latin patients, particularly the women in labour. She finds that her Scandinavian patients do not always know what they want, except that it must be something different. She encounters much stubbornness among them. Her Irish patients "make the ward lively," in more ways than one. The Russians show extremes of brooding and emotion. So it goes—the so-called national differences make themselves felt not less in the sick-room than elsewhere. But in considering these differences, the nurse never forgets that "meanings are individual," whatever the patient's race, nationality, or family may be. She never assumes that one patient is like another, although their race, nationality, and family may be the same.

(2) The differences due to sex. Nurses commonly maintain that "men are easier to take care of than women." Be this as it may, men are usually more easily reasoned with than women. As to the minor differences due to sex, the nurse soon sees that she can lay down no hard and fast rules.

(3) Differences due to types of intellect.—Mr. Thorndike says that individual intellects can be

divided roughly into two classes; those able to work with ideas and those able to work with things—the "idea thinkers," and the "thing thinkers." The nurse needs to consider which type her patient is, particularly when she is explaining something. She needs, too, to find whether her patient makes accurate and complete mental images. If she herself is able to image vividly, she must not blunder by expecting everyone else's mind to work the same way.

(4) Differences in education naturally have much to do with the variety of responses to the same thing. The training of the senses, the modification of instincts through intelligent systematic methods, the establishment of habits—all this must enter to a marked degree in creating differences of response.

(5) Differences of temperament and mood.

(6) Differences of circumstances surrounding each human being.

(7) Differences due to the weather and climate. It is literally true that people are at times "too hot to think" or too uncomfortable from wet or cold or pain to give normal attention to an idea.

(8) Differences due to disease, discussed in the next chapter.

2. The nurse recognizes the necessity of helping patients in the mental process of proceeding from the new to the old. As already indicated, patients must not be fatigued with detail or complicated expressions. Such words must be chosen

as will help the patient to take in the idea in the easiest fashion. She will not bewilder the patient by using words that are not in his vocabulary. If the patient's power of knowledge is lacking, if he cannot take in an idea or a situation without confusion, then the nurse must use her teaching powers wisely, so that the patient has the proper preparation for the new knowledge. Directness and simplicity should characterize the nurse's efforts to help the patient take in the new. That he needs such help must never be forgotten. Drugs, fatigue, disease—these things deprive the patient of a normal power of perception. Even familiar things may become strange to him during severe illness—he may actually at times have to take old things into his mind as if they were new. A word, a gentle movement of guidance from the nurse will obviate the patient's feeling of bewilderment and helplessness at such times. It is for this bridging over of ideas as well as for bodily care that the patient may cling to the nurse.

3. The nurse's tact in dealing with the patient includes the adjustment of a situation, an idea, to meet the patient's general attitude. She "gets around" the patient's ideas if necessary. She wins her way, finally, without any radical measures. She creates harmony by not trying to force the new too abruptly. Without the patient's realization, the fusion with the old is made quietly, easily. The nurse has triumphed. Sick people, both young and old, are often very stubborn at

the onset of disease and it requires considerable tact on the part of the nurse, to bring about a philosophical acceptance of the new conditions.

4. The nurse never antagonizes by direct opposition. She uses the negative sparingly. "Can't" and "no" and "don't" arouse antagonism very quickly. She has a stock of suitable phrases which she uses skilfully as a means of readjusting the patient's ideas. Certain well-tried phrases are a part of her professional equipment. She has great need for suitable phrases. Always she remembers, "Human resistance is universal." She has intelligence not to say the things that will rouse it. Even if she knows that her patient can't have what he wants, or, that he must do what he says he will *not* do, she avoids a direct statement to that effect.

"We shall see what can be done," "We shall do what is best for you, of course." "Shall we talk it over with the doctor?" These are easy and effective ways of answering the patient's impossible demands. A good way to manage a patient who insists upon having what he shouldn't have, is to question him indulgently as to just what he wants. Sometimes, by answering questions, the patient comes to see for himself, the undesirability of his request. Too much emphasis cannot be placed upon the recognition of human resistance.

The nurse will see evidences of the resistance to the new in the conduct of almost every patient,

but particularly of older patients, who are easily upset by changes.

It is often very difficult for a nurse to follow another nurse who has had charge of a patient for some time and become acquainted with the best way to manage him. The new nurse may be equally proficient, but the patient clings to the old —the new, in the form of another nurse, he resists. It is well in such a situation, to follow as closely as possible in all the little ways of the first nurse, so that the natural resistance of the patient will not be increased by radical changes. Gradually, the new nurse will win her place—she will wear old.

5. The nurse will remember that the old may take on in the patient's mind, a glorified aspect. Frequently the new cannot possibly be made to seem so good as the old. She will be indulgent with the patient's preferences and sympathetic when he "runs on" in extravagant fashion, comparing the new with the old.

6. In getting the patient to help himself, as in convalescence, or in establishing a new treatment in which the patient's co-operation is necessary, it is essential for the nurse to follow closely her patient's mental processes. She cannot make use of a mental microscope, unfortunately, so that she is unable to determine exactly how her patient's mind works, but she can keep in touch to a helpful extent. She must always be thinking of how the patient is taking things into the mind, else she will be of no use in getting him to help

himself. This problem of getting the patient to help himself is one of the most difficult. He must have assistance in developing the initiative.

7. The nurse knows that there is a time for everything—including when and how a patient should encounter a new idea, a different situation. Among the many practical nursing rules given by Celsus[1] is the injunction that if the patient must hear something unpleasant, he should hear if after a nap, following food. Although it was recognized as far back as the days of early Greek nursing that perfect quiet should prevail during and after the patient's meals,[2] we find nurses of today very often thoughtlessly chatting with their patients or allowing visitors at this time.

Topics of conversation must be carefully chosen in the sick-room if the patient's mind is kept serene. The reason that visitors so often do the patient "more harm than good," is because they do not show discretion in choosing things to talk about. Patients could stand more visitors if they only knew what to leave unsaid. Visitors from the world outside the sick-room too frequently bring with them the restlessness, the jar, the tragedy of that world. Naturally, they cannot bear these things without a bad reaction. They quiver under the narration of anything harsh or painful. The wave of restlessness from the outside overpowers them with fatigue. Sometimes visitors go to the

[1] Celsus, born 50 B. C.

[2] Nutting and Dock, *History of Nursing*, p. 80.

extreme in trying to "be cheerful" in the presence of the patient. With their minds set upon this duty, they force much laughter. ("Can it be," thinks the patient, "that human laughter can sound so hideous?" He refrains with difficulty from stopping his ears.) The visitors laugh on, recounting in a rapid-fire of gay chatter, the pleasures of their existence. ("After all, they care nothing about *me*," broods the patient miserably. "All they think about is the good times they are having.") He feels abused instead of comforted by their visit. He is glad to see the door close behind them. It is difficult indeed to sustain the right sort of sick-room conversation. The patient must not be allowed to talk *too* much about himself—on the other hand he must be made to feel that his friends are intensely interested in his progress and sympathetically eager to hear about his particular symptoms. He must not be told tragic, gloomy things, but he can't be expected to laugh very heartily at well people's jokes. He wants to hear news of what his friends are doing, but too spirited an account of activity, of life brimming with joyousness gives him a feeling of depression. Instinctively he contrasts the good fortune of others with his own sad plight. He is submerged in self-pity. So it goes—we are undeniably put to a hard test when we try to talk to the sick. Little things are always safest—little pleasant comments on things the patient likes—a gentle ripple of talk that will buoy the patient up

without exciting him unduly. The caller who knows how to talk to the patient leaves him the better for the visit.

The nurse knows when the patient will not take in a bit of humour with good grace. There are even times when he may resent joking remarks. It is never safe to assume that a patient is receptive to humour just before an operation. If the nurse's attitude at this time is cheerful and matter of fact, without any impression of "forcing the jester," the patient is kept in a more serene state of mind. Little everyday remarks do more than specially prepared jests to take the patient's mind off the ordeal and to make him feel that, after all, it may not be such a terrible experience. Silent preparations are often translated as ominous by the patient. The nurse will avoid an air of something momentous on foot. At the same time she will have the good sense to strike a nice balance. Patients like to feel that due consideration is given to their operations, minor though they may be. If the nurse is too obviously unimpressed and gay about it all, "she has no sympathy," says the patient to himself. "She's so used to it, she doesn't care."

If the nurse says anything at all in the way of sympathy or cheer, she is careful that it does not sound stereotyped to the patient. If her spirit is sensitive, her guardianship of her patient sincerely tender, she will be sure to say the right thing at the right moment.

Hitting upon the most opportune time for an effort at replacement of ideas is vital for the success of such work. The golden psychological moment for replacement, when the interest can be caught most easily, is the moment of least resistance.

8. A single word may colour the patient's impression. Therefore the nurse speaks with exquisite care. She is never done with the study of her own language and the languages of other nationalities. Even a little knowledge of French, Italian, Spanish, and other languages helps the nurse to get her ideas across.

Let the nurse remember that speaking in a loud tone does not help a foreign patient to understand English—unless, of course, he is deaf. Nurses should avoid the tendency to shout at foreign-speaking patients as if they are indeed "hard of hearing." Clear enunciation is imperative, however. If the nurse mumbles her words, she must not be offended if her patient says that he can understand English but not "the way the nurse speaks it." It is often difficult to interpret the new to the foreign patient. Explanations in a language of which the patient knows only a few words, sometimes bewilder more than they help. However, if the nurse attempts to speak in the patient's native language, let her be very sure of herself. If she misuses a word she may create as much havoc in the patient's mind as if she were speaking in a language strange to him.

9. The nurse needs to remember that the patient, as a rule, has many false perceptions, *i.e.*, illusions and hallucinations. Wrong suggestions given by sensations are a part of the patient's experience. The sense-organs are often stimulated in obscure ways in disease, and hallucinations arise. Illusions as the result of misinterpreted sounds are among the most common. Patients are constantly thinking, when they listen to the wind, that they hear voices. It should be noted that *fear* is an element in almost all illusions and hallucinations of the sick—fear of the patient for his own well-being or of those dear to him. In delirium, so full of the wildest hallucinations, the patient is sometimes possessed by such a degree of fear that he is in a frenzy. Every effort should be made to dispossess his mind of fear. Even if he cannot be persuaded that the hallucination is such, at least he may be made to feel that he is out of reach of its terrors. A patient, who was writhing on his bed in horrible fear of the live wires he said he saw descending upon him was quieted by the nurse's easy explanation that she could control them and that they would never reach the bed. Sometimes it is better in dealing with a delirious patient not to tell him he is only imagining things, but to rid his mind of any disturbance over the hallucination. However, each patient must be managed according to his particular needs. Occasionally, a patient is reassured if the nurse says that she herself cannot see or

hear the thing that troubles the patient; but often the patient is persistent in his belief in hallucination which may become only the more sinister if the nurse seemingly is not sharing them. Sometimes a gentle humour, combined with the magic of the pronoun "we" instead of "you" will do wonders. A flicker of amusement on the part of the patient over a situation someone else is sharing with him, may dispel much agitation. The nurse may not be able to dispel the hallucination, but she can usually manage to induce the patient to take an undisturbed attitude toward it. He may be made *to regard hallucination as illusion.* The nurse should not forget that even a slight degree of fever may give rise to false notions. She should ever be on the look-out for such manifestations, no matter how normal the patient's mind may seem to be. Dream hallucinations are commonly to be expected in sickness. A patient may awake with a start, and, still controlled by hallucination, leap from his bed, or in some way do injury to himself. This is one reason why patients who are in a serious condition should not be left alone while sleeping. Certain drugs tend to produce false perceptions. In recording false perceptions the nurse should discriminate very carefully between illusion and hallucination. In certain mental conditions it is very important that the physician should be informed of the patient's hallucination or illusion. The nurse will not say that her patient is "imagining things" when he really has

false perceptions. It is true that patients who have vivid imaginations may readily perceive things falsely, particularly under the influences of certain medicines—but there is a discrimination to be made. Imagination, as explained by psychologists, is not false.

Hallucinations are not pathognomonic of any particular disease. However, as expressed by Henry Mehrtens of Stanford University Hospital,

> There are certain hallucinations which would suggest certain types of mental disease.
>
> First of all, the hallucinations in delirium tremens are fairly consistent. The hallucinations of pink rats, snakes, rabbits, and other animals are well known to the laity, and upon these they frequently make their diagnosis. The hallucinations in which dead people in coffins are a part are frequently suggestive of delirium tremens.
>
> In *arteriosclerosis*, hallucinations of hearing are frequent. Also in deaf people, or in those losing their hearing, tinnitus frequently merges into hallucination of sound in which the patient hears music, voices, even long conversations.
>
> The hallucinations of *dementia præcox* and of paresis of the insane are influenced in character by the deteriorating type of disease. These hallucinations both demonstrate lack of judgment in the patient—for example, a paretic carried a basket about with him and when questioned as to its contents, replied that he was carrying his head in it. The cases of *dementia præcox* frequently indicate an enfeebled critical sense—patients who believe their organs have

been extracted or that animals are enclosed in their vital organs, that snakes are inhabiting their brains, etc.

The nurse never gains anything in her control of such patients by ridiculing their hallucinations, or showing the least impatience. A patient suffering from *dementia præcox* thought that her heart was in the nurse's pocket. The nurse showed good judgment in assuring the patient that she was taking the best of care of it. The patient was quieted, and apparently untroubled so long as the nurse was in sight.

## Definitions

*Hallucinations.*—Between normal perception and illusion we have seen that there is no break, the *process* being identically the same in both. . . .

In ordinary parlance hallucinations is held to differ from illusion in that, whilst there is an object really there is illusion, in hallucination there is no objective stimulus at all. . . . An hallucination, subjectively considered, is a sensation, as good and true a sensation as if there were a real object there. The object happens not to be there, that is all. . . . The hallucinations of fever-delirium are a mixture of pseudo-hallucination, true hallucination, and illusion. (William James, *Psychology*, pp. 330 and 332.)

## Questions for Study

1. What is apperception? Perception, as distinguished from apperception?
2. What is the general law which makes itself

felt in apperception? Why does the nurse need particularly to remember this in dealing with her patients?

3. What basis is necessary to the nurse in the study of Materia Medica? Household Economy?

4. What studies of the nursing curriculum do you find most difficult? How do you account for this?

5. In criticizing the way a convalescent patient has done a piece of occupational therapy work, exactly how should you word your adverse criticism? Your praise of good work?

6. What particular points should be considered in arranging occupational therapy work for patients?

7. How may you get in touch with a patient when he comes under your care?

8. (a) Enumerate racial and national characteristics you have noted in patients.

(b) Give examples of "thing thinkers"; of "idea thinkers."

9. Give some examples of conduct which was the result of the fact that human resistance is universal.

Give an example of a skilful reply which showed recognition of human resistance.

10. What makes the tone of your training school?

11. What are the duties of "the keeper of the mind?"

12. Give an example of a funny saying which shows the effort to name something new according to what is already in the mind.

13. What is it to "die young?"

14. What points does the nurse need to remember concerning taking things into the mind?

15. What points in regard to apperception are helpful to the nurse in getting on with her patient?

16. Give an instance of a different reaction of

patients to the same idea. Give the probable reasons for differences.

17. (a) What hallucinations have you observed in patients?

(b) Mention dream hallucinations and illusions which you yourself have experienced.

18. Mention an instance when a patient was disturbed by a dream hallucination.

19. Select a single subject or idea new to all of our five nurses. Indicate the reasons for the different reactions. Specify what each girl needs in the way of mental equipment in order to take in the idea properly.

20. Give the exact words you would use in explaining to a patient who speaks only a little English that he is to have a test meal.

21. What is there in the general attitude of E. J. Andrews that will prevent him from "dying young?" How may he lose his fear of old age?

22. The husband of a patient in the clinic obstetrical ward comes to the information desk at 6:30, P.M. and says, "I want to see my wife, Mrs. E., in the obstetrical ward."

Select from the following replies, the one you consider the best. Tell what principle of psychology is to be considered in framing a reply to such a request:

(a) "No, you can't see your wife now. The rule is that no one may be admitted before seven o'clock."

(b) "You ought not to come before seven o'clock. You can't see your wife until then."

(c) "Certainly, at seven o'clock. Visitors are admitted at that hour. Please be seated in the waiting room."

23. Suggest suitable answers to the following questions:

MRS. TELFORD WORTHINGTON: "I hear the patient in the next room crying out in a queer way. I believe he is out of his head—it makes me so nervous. There is no telling what he may do. What is the matter with him?" (See note.)

NURSE:

24. PATIENT: "What is my temperature today?" (See note.)

NURSE:

25. PATIENT: "You have worked so hard taking care of me—I want to make you a present. What should you like?"

NURSE:

26. DELIRIOUS PATIENT: "There is a skeleton rattling the window—I can see him trying to get in here at me——"

NURSE:

27. PATIENT: "Is Dr. B. a good doctor?"

NURSE:

28. In hearing visitors talk to patients, do you observe that they know what is best to talk about? Mention topics which should be avoided. Mention some topics of conversation that almost any patient would be interested in. What special things would interest each of our five patients?

29. Take note during a day's duty of the general use of "don't" and "no" and "can't." Write out different ways of expressing the same things, so that less antagonism would be aroused.

30. Give an example of a wrong idea caused by the nurse's inattention to detail in taking in a new situation.

31. When is the most opportune time to attempt the replacement of ideas?

NOTE: It often happens that commotions in the hospital upset other patients and one of the hardest situations a nurse has to meet is that of quieting a patient and at the same time refusing to tell what is going on. "There is nothing whatever for you to worry about," "The patient is in good hands," "Please don't be upset—everything is all right." Such responses may safely be used in the most trying situations with good effect, particularly if the nurse maintains a quiet unruffled demeanour. Sometimes in an unusual situation in hospital or home nursing, it is necessary to inform the patient of "what is going on," but if such a necessity arises, the nurse must be careful to state the occurrence in the simplest, least upsetting fashion. Rarely, however, is it wise to tell the patient about things of disturbing nature outside his own sick room. It is comparatively easy to keep things from patients if those about them practice self-control and good sense

One of the most usual questions of patients is "What is my temperature?" It is always best for the patient not to know what his temperature is, even if it is normal, because the patient must not get into the habit of following his disease, of wondering what his temperature is going to be, since this brings about a detrimental tension. The patient must relax absolutely, and give himself up to the care of the nurse and the physician if the best results are secured. His temperature, his symptoms are not his concern. Sometimes patients do not really care about knowing their temperatures, but amuse themselves by asking, merely to "hear what the nurse will say." What can she say? Her adroitness in adjusting herself to the particular situation must decide that. "Do I look

like such a very young nurse?" she may parry, or, "Is our patient trying to find something to worry about?" The patient must be made aware that it is the professional rule not to tell the patient his temperature, to let him see his chart, to inform him of the significance of symptoms. Once he understands that absolute relaxation is for his own good, he will stop asking questions the nurse will not answer. If the explanation of withholding chart information is made upon this basis, the average patient will be reasonable and quickly lapse into the desired passivity. He must never be allowed to think that things are withheld from him because they are of an alarming nature. "The chart is for the doctor. We want our patient to 'let go' of all possible worry—to relax entirely. It is for this reason, not because your temperature is alarming or unsatisfactory, that we do not tell you." Some such answer will easily come to meet the particular situation, if the nurse has in mind always the general impression she wishes her patients to have.

## References

Colvin and Bagley, *Human Behaviour*, Chapter 13.
Pillsbury, W. B. *Essentials of Psychology*, Chapter 7.
James, W. *Psychology, Briefer Course*, Chapters 19 and 20.
—— *Talks on Psychology*, Chapter 14.

## Questions for Re-education

1. What particular tone or atmosphere does my personality help to create in the society in which I move?

2. Do I argue in trying to make other people accept my ideas? Do I realize that other people cannot think exactly as I think because meanings must differ according to each individual make-up?

3. Have I established a keeper of my mind?

4. In what ways do I show myself "a young fogy"?

5. Do I use the negative too freely? Do I always word my expressions so that I rouse as little resistance as possible?

6. Do I always know how to avoid telling a patient what I know he should not be told? Am I adroit and quick with the suitable answer to a difficult question?

7. Why do I get on better with some patients than others? Is this the fault of the patients or myself?

8. In following another nurse, do I know how to subordinate my personality in order to fit in gracefully?

9. What have I done today that showed lack of thought concerning how the patient was taking an idea into his mind?

10. Do I assume that I understand people completely? Do I make set and definite judgments, regardless of the fact that I cannot possibly make a complete inventory of others' minds?

11. How may I keep myself receptive to the new?

12. Do I analyze carefully the reason I do not like certain studies, regulations, changes?

13. Am I inclined to think that people of one nationality all have the same characteristics?

# CHAPTER VIII

## RESPONSES OF PATIENTS

Of all the things which influence responses—weather, fatigue, emotional state, mood, temperament, purpose, and so on—the nurse is most directly concerned with the influence of disease. Wisely, she never tries to pigeon-hole her patients in hard-and-fast fashion, because, outside of the influence of disease, there are so many other things which make individual differences. Let us repeat, *each patient must remain a human being with responses peculiar to himself.* However, as regards disease, the nurse sees her patients naturally, in four groups:

1. Patients who must die, with more or less dispatch.
2. Patients who are going to get well.
3. Patients who are at a standstill, indifferent about living.
4. Patients who are "incurables," "chronics."

There are certain responses characteristic of each group, and, although the nurse knows that she may expect something different from each member of a group, this classification helps her somewhat

in "knowing what to expect" in a general way.

1. Of the first group—those who must succumb to disease—the nurse finds that the majority take the idea of death into the mind unwillingly. The average patient does not want to die. He is not done with life. He does not want to give up to disease. He resists, he fights the idea according to his strength. He may say, nevertheless, "I am not afraid to die,"—always a cheering reassurance to those who watch over him; or, he may approach the end in terror. The retractive instinct shows itself often in timidity or fear. The patient would get away if he could—but there is no hiding or fleeing from death. He is "blocked"—terror and despair lay hold of him. Even patients who have the spiritual courage to face death unperturbed feel now and then waves of physical fear or dread. The living body to be vanquished, robbed of its senses, all its wonderful mechanism at an end—the living body to become a dead thing, rotting in the ground or burned into ashes—*no, no, no!* The repulsive instinct asserts itself, but death will not be thrust away. The disgust that results is a physical repugnance natural to everyone. The spirit alone may conquer it.

So completely may disease get the upper hand that there is often pitifully little left of the patient to show any kind of response. The conscious being is overwhelmed. The young nurse is always a little bewildered at first over the way most patients die—so unaware, so helplessly sinking

away, so bereft of the power of response to any stimuli—passing with such strange quiet—to what?

"Why, he didn't know he was dying—he didn't say anything—nothing happened," exclaims Bessie McCaskell after seeing for the first time a patient die. "He didn't die the way they do in books—there was no 'death-bed scene' of that sort. He seemed just to slip away——"

So it is—more often than not, patients "slip away." Their fear has been for naught. With an understanding of the natural repugnance of death, the nurse may do much to help the patient get rid of such feeling. If the patient with the wonder of a child asks of her, "What is death like?"—a question no mortal can answer—let her not be confused. At least she can comfort him by telling him of the gradual, merciful sinking into oblivion, so commonly noted. Fortunately for the nurse the patient seldom voices his questioning about the unknown.

Occasionally, the nurse will encounter in this first group, a patient who wants to die. He is glad to have done with life. He may be spiritually beaten—life, not death, fills him with despair; or, he may be so worn out, so overcome by terrific pain that death holds no terrors. He welcomes his release. The nurse can only help the patient maintain his anticipation of better things to come. Even these patients who say they want to die suffer at times from physical fear of "the last"—what

struggle will they have to undergo to obtain release?

Sometimes patients are "a long time dying." Death stares them in the face, day after day for weary weeks or months. Such patients need special help. Gradually the idea of death at least loses its newness. The patient ceases in a measure to resist it. He begins to speculate—to wonder. Can he look upon it as an adventure? A long journey in a strange land? Will there be Some One there to look after him as when he came on earth to be a little child, and as now, when with the nurse and friends at hand, he is leaving? Or, is it just oblivion? The nurse may help, without intruding her religious views, in making the patient think of death in a natural everyday fashion. She is not mournful and solemn when she promises to attend to some last requests for him. It is possible to make such things interesting, even entertaining for the patient. She will try to "make things pleasant" to the end. The dying man, so long as he is conscious, does not like to be treated as if he is done for. So long as there is a spark in him, that spark is worth the nurse's tenderest care.

2. The second group—made up of those who are going to get well—is by far the largest. The nurse sees far more of living than dying. These patients who are on the road to health are the easiest to deal with, simply because they feel themselves victorious. They think of death as beaten. Why, of course they are not going to die—life is all before them. How happy they are

over their returning powers—how eager to get into the thick of things again! Never have they taken such delight in their senses. An exhilaration—almost an arrogant laughing defiance of disease possesses them. Their responses to every sort of stimuli show a decided difference from the general responses of any other group. For example, any occupation during convalescence seems merely to him a thing to pass the time—he has other things awaiting him, so that he can give only tolerant interest to the thing in hand. The "incurable" grasps at occupation as the one thing that can help him to govern living. Patients who are going to get well show themselves docile under almost any treatment as soon as they realize it has to be gone through with to restore their health. They often develop a fine courage in bearing pain. "Easy enough to stand it—I'll soon be well. That poor devil in the corner—he may well whimper over his dressing. He will never see the last of sickness." Thus they consider their advantage. The nurse has fewer "management problems" with the average patient whose illness is of short duration than with any other kind of patient. He does what the doctor and the nurse say is best for him to do because that will make him get well the faster. He takes great interest in his symptoms—he is always asking questions about himself. His mind is lively enough usually to take care of itself. He is taken up with getting well. He leans less and less upon the nurse. Keeping him quiet,

free from fatigue, curbing his impatience,—this keeps the nurse busy. To nurse a human being back to his place in life has an unending thrill to it. The nurse can only regret that not every patient goes back to a place of real usefulness in the world. Sometimes a sickness may readjust the patient's ideas of living. He may get something spiritual out of his sick-room experience. He may be brought sharply to a different valuation of things he previously sought in life. Many good resolutions are made by patients while they are getting well. The nurse listens sympathetically. If only they would hold fast to these resolutions after they go out of the sick room! The world outside, pulsing with its old appeals, gets them again—the same old responses make up their lives. How soon they forget, the most of them! The nurse who knows so well her patient's lofty turn of mind as he goes from her needs usually to be a bit philosophical when chance brings the "well patient" under her observation again. But she is glad for him—he is strong again—he has his opportunity with life. Perhaps, after all——

3. Out of her many patients, the nurse seldom encounters one who does not *want* to get well. It is unusual to find one who is not glad when the doctor tells him he is going to live. For a patient to turn from life within his grasp is not to be expected normally. However such patients exist. Their histories are often dramatic. Patients who actively combat the idea of getting well almost

invariably find it difficult to face life again because of hard experiences, continued bad luck, or tragedies. The instinct of self-assertion may be crushed by "hard knocks." There is no dominance, no pride in living left for them. Nothing has come out right—nothing is likely to come out right in the future. What is the use? Such pitiful types often come under the nurse's observation in the free wards. Not always are these patients of the poverty-stricken class. Many a luxury-bound patient feels that he has made a sad bungle of living. Would-be suicides are often apathetic about taking up life again. All such patients are difficult to deal with because they will not help themselves to get well. They stand still all because they will not make the necessary effort. They must be made to feel again something of the fighting spirit. They must throw off humiliation at failure, shame over past misdeeds, indifference to the possibilities of living.

Among the patients who are indifferent about getting well are certain types of nervous patients. They say that they can't take an interest in things. Life seems deadly dull with no possibilities worth while. Greyness—all greyness. They must be made to *expect* colour. Perhaps they are possessed by the idea that they cannot get well. It is sometimes a difficult matter to make a patient of this type realize that he has the power to throw off disease, that he can do more for himself than anyone else can do for him.

Sometimes patients are at a standstill because they are worn out by a long illness. They are tired out. They cannot take in completely the idea of living again. Their minds are held seemingly in a sort of lethargy. It is too much of an effort to get well. Their little circle of a sick-room existence contents them after a fashion. There is a certain protection about the sick-room that comforts them in their weakened state. The thought of meeting the bustle of the outside world is distasteful. If they were strong enough—perhaps it might be endurable—but they feel too weak even to entertain the thought of it. To be taken care of, to make as little effort as possible, to drift along—this is easier. At times it is hard to make such patients believe that they are getting better—that they could be well if they would only help themselves. They may even resent an optimistic view of their condition.

"You don't realize how sick I am," says such a patient. "I am just the same—not the least bit better."

Where is the old self? His friends wonder sadly. He must be helped to get the old self back, before he will take a normal view of living. Patients who are indifferent about getting well must be made to bestir themselves or they may reach the point where they cannot get well. No longer will they be at a standstill. They will lose against disease. Each patient requires different stimulation, but somehow the desire to get out of the sick-

room must take hold. The replacement of ideas must be brought about skilfully as patients of this class usually resent it when any one "tries to meddle," to force them to give up their sick-room habit of thought.

4. Patients who are incurable with a long stretch of life ahead remain the most difficult for the nurse; and yet the very intricacy of each individual problem has its fascination. Certainly to salvage what is left of a human being is one of the greatest triumphs the nurse can achieve. To make use of an incurable—this is his salvation. To leave him alone—his mind to feed upon despair—this is his doom. His tendency is naturally to melancholy and despair. Life has passed him by. His mind must be occupied in some way—by listening to intelligently chosen music and to stories that keep his mind off his own condition, following baseball scores, listening to enlivening conversations, playing games, making things after models, or, best of all, by creating something. He must be made to feel that there is something left for him in life. The nurse will need much ingenuity to find use for the wrecks of humanity that come her way—to make life good again for them—but may she never give one up as done for!

In addition to considering her patient as influenced by disease, the nurse *must study him for individual differences*, that bring about such a variety of responses to the same stimuli.

## Questions for Study

1. As regards the influence of disease, what characteristic group responses does each of our five patients show?

2. Which one of our five patients is most indifferent to living? How may this patient be helped?

# CHAPTER IX

## PUTTING TWO AND TWO TOGETHER

"PUTTING two and two together"—otherwise known in psychology as *association of ideas*—has two fundamental laws, set forth centuries ago by Aristotle. Psychologists have discussed these laws, turned them inside out with care, but they have never ventured to change them:

1. *The Law of Contiguity.* If the mind takes in two objects at the same time, thereafter a relationship exists between these two objects. If one of the objects presents itself, by this law of association, the other comes to mind. The nurse, seeing the appliance for estimating the degree of blood pressure, thinks immediately of its name—sphygmomanometer, because she learned the use of the instrument and its name, not without a struggle, at the same time. She recognizes the instrument used for subcutaneous injections as a hypodermic syringe—the recognition of the instrument and its name come to her simultaneously. So it is with other appliances used in nursing procedures and with all objects which enter into her world of experience. The law of contiguity

makes links of great variety. Somebody speaks Mary Anderson's name—Mary herself comes to the mind of those who know her. The nurse learns the bones of the forearm. The natural law makes her think of the radius in connection with the ulna. Solution formulas, colours of the spectrum, recipes for fudge, jingles—each of these is made up of related bits, of one thing plus another belonging together in the mind.

2. *The Law of Similarity.* Not all objects taken into the mind are linked by the law of contiguity. One thing may suggest another because it is similar to it, because there is some analogy between the things which come, one after the other, into the mind. Isabel Terry's mind is drawn off the subject of a lecture, because she sees something in the lecturer's face that reminds her of a goat—hence the caricatures, covering the pages of her note-book. "I'll have to borrow your notes," she explains to Ann Sherman, "because the lecturer looked so like a goat." He did not remind Ann in the least of any such animal—her orderly notes testify to the fact that her mind was not disturbed by the same similarity that upset Isabel. Frances Tracy is set dreaming by a flash of pomegranate and blue and gold, because this colour combination to her is "like the tropics." Mary Anderson cannot explain just why little babies make her think of the pasque flowers on the ranch hills in the spring, but the link is there. . . . This law of similarity includes contrast.

Bessie McCaskell, who is always looking for differences, thinks of the prettiest girl of her acquaintance when she sees the homeliest, or of white dresses when she sees black. As made clear by observation, as well as by psychologists' comment, this likeness or difference is something that the individual reads into his own experience. Whether one person finds likeness and another difference, whether the experience of one resembles the experience of another, depends upon the individual point of view, or the idea he has in mind when he makes such comparisons.

Association makes the box of keepsakes a treasure to the owner. The same objects appear worthless trifles to another. . . . I once had a little china clown—dearest to me of all my childish possessions. With his arms akimbo, his face crinkled in an irresistible smile, he was to me the embodiment of fun. He could set me laughing any time. I could not leave him behind with other childhood things. He stood, as time went on, for a more grown-up philosophy of mirth. He meant a great deal to me—this battered little clown. He seemed to understand so well what was really funny. Moreover, he helped me to laugh when it was hard to laugh. I wanted to take him with me "out into the world." Alas—someone busy "tidying up," saw him only as a ridiculous outgrown plaything and he was cast as worthless into the rubbish, thus lost to me for good. My grief was not understood—there was that about my

little clown I could not explain. Many times I have wanted him. And, if I could "magic" him back this minute, he should have a place of honour, no matter how absurd he might look to any one else. . . . Revolutionary experiences often occur in our associations. We may dislike an object, but because of the part it plays in doing us a good turn, we look upon it with entirely different associations. An inartistic wall ornament, a family heirloom of carved metal, which seemed to the daughter of the house "too ugly to look at" took on a different aspect after it had saved her mother's life by deflecting an accidental bullet. . . . An object to which we are indifferent may, through unusual experiences, become associated with vital considerations. Who in America does not look with different associations upon our flag after the emotional experiences of the war? It has a power to stir us now as it never stirred us in the past. An inoffensive article may become an object of loathing, by its connection with some revolting experience.

What we are "getting at," our prejudices—likes and dislikes—have much to do with association of ideas. Many girls in their romantic tendency to idealize people they like, see in the objects of their worship, likenesses to heroes and heroines of history. Such hero worship appears ridiculous to other people. If we have "a natural aversion" for someone, it is difficult for us not to associate undesirable motives with his actions; it is hard to see praiseworthy things in his conduct. The

injustice of such associations is apparent. We live upon a petty level, indeed, if we cannot free ourselves from such unworthy associations. We should be able to see that which is fine in our dearest enemy. The old saying "We can always see what we are looking for," is significant. Must we always associate past mistakes with people? Must such people remain forever in our minds incapable of anything different? "Once he . . ." ah yes, a wrong deed, unquestionably—but what was the reaction of the mistake upon the individual who made it? Did it drag him down further, or bring him to his senses? Do we stop to think of that point? Evolution is a mighty word. Justice demands that we think of a man—not as he was yesterday—but as he is today. May we be broad-minded enough to give the credit due to any one who tries to make something beautiful out of his life, whether such a one has a history of mistakes or not! May we master our old associations and clear our minds of unfairness!

We maintain the points of our philosophy of living by designating various everyday happenings as illustrative of the particular principles we embrace. To prove that the play instinct cannot be stifled without detriment, we cite examples of bad effects we have observed in our study of children. . . . We sustain all of our discussions by "examples" of everything under the sun—such examples being related to our ideas, as we maintain, by the law of similarity.

The nurse often encounters, in her work, minds that are perverted by unwholesome associations. One of the most difficult things the nurse has to do in social service work, is creating different associations. Children—and not always children of the gutter—are hampered in the development of fine ideals by unfortunate associations. "How did the child get such an idea?" exclaims the horrified mother, when her child voices an association which befouls purity. How indeed—except through the mother's disregard of the laws of association? Nothing is of too little consequence to consider in "organizing the ideas to be associated with ideal interests" of the child. It is often the trivial association which leads to definite perversion.

In addition to the two primary laws of association, we have what psychologists call the secondary laws of association:

1. The *law of frequency or repetition*, which needs no explanation further than that we naturally associate things which are repeatedly taken into the mind together. In considering habit, the repetition of associated ideas cannot be disregarded.

2. The *law of vividness*. We remember vivid experiences, simply because they have strong associations for us. The same circumstances may or may not make strong impressions upon other minds. The day upon which a man and a woman are married remains always a special day upon the

calendar to them—the date has vivid associations not experienced by others. Every person has "red letter days" in his calendar. Events and objects have power to arouse strong associations according to the circumstances which bring them into an individual's existence. Certain books of my library are associated in my mind with unusual events—to me they are not like other books, but to my guests they suggest nothing different from the rest of the volumes.

*The laws* of *primacy* and *recency* are so closely related to vividness that they can hardly be called separate laws. When a series of things, naturally related, is recalled by the mind, the *first* of the series stands out most clearly. The nurse recalls the first days of her hospital experience more definitely than the days that follow. In writing home, her letters are filled with "first impressions" which remain the most vivid of her training, except the last. In recalling a lecture, the nurse more easily recounts the first points. When we look at a long procession of floats or at many pictures, we remember the first and the last one most clearly. In describing our experiences, our accounts usually enlarge upon the beginnings. We recall less detail of the later happenings. . . . At the end, more detail enters in. According to the law of recency, we naturally remember vividly the most recent happenings.

Sounds, signals, odours, and so on, become significant, let it not be forgotten, according to the

attitude of those who take in the impressions. The nurse's world is made up of highly important sense impressions, which call to her professional response. The same impressions may hold nothing but an ordinary significance to a visitor. Certain associations may be aroused very vividly in the nurse's mind by things which entirely escape the notice of the casual observer.

"Congruity of Emotional Tone," as mentioned by James, may be interpreted as signifying that objects and events are linked in association, as they fit the mood of the individual making the associations. We like to take along with us upon a motor trip a companion who starts out expecting everything to be pleasant and by his optimistic point of view, sees adventure in what is commonly termed "delay." We avoid including in the party, one who is "afraid something is going to happen," who sees in every turn of the road a possible accident. Equally undesirable is the person whose mind is set going by the passing panorama—his ideas uncontrolled, his remarks flowing forth in scattered fashion. A beehive reminds him of a dear friend who loved bees, a white horse of one he himself used to ride on his uncle's farm, a cat scurrying across the highway recalls the fact that cats carry disease and so on. Nor do we want to take with us the gloomy individual who positively can't see anything of interest. He remembers only the disagreeable things that happen. We *want* and enjoy the person whose associations

have organization, whose tastes and feelings are such that his impressions are fine and wholesome.

*Control of associations.* A shrewd housekeeper once said that she could tell how the girls in the dormitory kept their ideas by the way they kept their dresser drawers. Be that as it may, certain it is, there is a great difference in the order of people's minds. The nurse, keeping in mind always the highest idea of education, becomes aware that it is not enough to have a store of unconnected knowledge—she must put her impressions together in a systematic way. Everything has its place in her mental storehouse. When she gets anything new, she knows where to put it. She never forgets the need of the keeper of her mind. This keeper of the mind actually controls the associations.

Associations are most easily formed, naturally, if the interest is keen. Once a genuine interest is aroused, repetition brings about the desired permanency. *Organization* is the principle of association most emphasized in psychology. Linking an idea with other ideas, "sorted" for a definite purpose, will do more than anything else to control associations.

Concerning her own associative processes, the nurse in achieving re-education, will need to make use of such helps to control. Through clear-cut organization of ideas, she will attain new order, and richness of mind.

Concerning the patient, the nurse may find useful the following observations:

1. The dominance of the instinct of fear has already been dwelt upon. More often than not, the nurse will note that the patient is afraid—not of one thing—but many things. Fear hovers about anything and everything—his associations are governed by this emotion. Perhaps he sees something to fear in "the way the doctor acts," or he is afraid he has been given the wrong medicine. He fears the effect of the new treatment will make him worse than better. He believes he can't get well—even a mild disease overwhelms him. During an epidemic, the nurse will see many examples of panic over nothing of consequence.

In delirium, particularly of the milder sort, the patient will show *scattered fear*—that is, he has a variety of associations all coloured by abnormal fear. The shadows, the nurse's ghostly white uniform, the doctor's simple instruments used in dressing his wound—all these strike terror to his heart. Or, the patient may have some other idea than that of fear which controls his associations.

2. In more pronounced delirium, the patient frequently has a "fixed idea." Everything clusters about this idea—everything else is subordinate to it. Nothing seems to eradicate it from his mind. It is always there ready to find expression at any moment. Sometimes a delirious patient with a fixed idea of escape or of getting out of bed will watch his opportunity with great cunning.

It is never safe for the nurse to assume that the patient has become dispossessed of his idea. Once in his mind, it is likely to stay until his delirium is over. Be the fixed idea of delirium what it may, the nurse must expect everything in the patient's mind to revolve around it. As previously suggested, it is often well with this type of patient to "humour" him. Opposition can never get the better of the fixed idea. The nurse's greatest tact is required in dealing with patients of this type, and controlling them in their delusions.

Not all patients who have fixed ideas are delirious. Many of the most difficult types of nervous patients show this state of mind. It is to be noted that the so-called fixed idea is by no means the *same* idea. It has points of similarity to the extent that it may seem without close study, to be identical. James says, "A permanently existing 'Idea' which makes its appearance before the footlights of consciousness at periodical intervals is as mythological an entity as the Jack of Spades." The nurse will note the fluctuations which slightly alter the dominating idea. . . . The patient with a "notion" is likewise controlled by it but for a briefer time. He may "get over" a notion in a twinkling if the nurse is skilful at suggestions. The persistent or fixed idea dies hard.

3. In studying the minds of her patients and of other people, the nurse will be impressed by the general lack of order. She must not expect everyone to think clearly because everyone is not

trained to well-ordered associative processes. She meets many patients who seem to "take things in" but cannot "make anything out of them." In social service work, she must guide the associations of those she hopes to help. They cannot, by themselves direct the course of their associations.

4. The nurse, understanding the effects of associations, will take great care in protecting the patient from unpleasant and undesirable impressions. A very little thing may "set the patient going" as the old-fashioned nursing expression puts it. Of course the nurse cannot know just what connection an impression is going to make in her patient's mind—she can only study him for hints as to his prejudices. The patient's tastes give the nurse her key. An unfortunate connection is not always set right at once. The nurse will understand the desirability of preventing an unwholesome state of mind, as well as building up a desired attitude by way of many minor associations. A course in associations, if we may put it so, is necessary sometimes before an essential interest can be created, a purpose developed.

5. The nurse will need to help the patient to organize his thoughts about getting well. Her instructions and care cluster about health for her patient.

## Definitions

"*Three Essentials in Efficient Learning.*—The application of the law of association to the control of

mental life by school education and general training are clear. In briefest terms they are as follows:—

The first necessity of mental progress is fertility in response. Unless the baby does something, it can learn nothing; there is nothing for selection to work upon. Intellect and character can not be created from a void. Other things being equal, the capacity for varied responses, great activity, curiosity, and mental energy increase the probability of mental improvement.

The second means of training is the arrangement of instructive situations—of conditions the responses to which may form valuable associations. As civilization progresses, men try increasingly to provide in the home, in schools, and in the world's affairs, situations fitted to induce profitable responses. The behaviour and conversation of the people about us, the books, laboratories, museums, and other school paraphernalia, sermons, newspapers, music, laws and the like—all aim to control the mind's acts by controlling the situations to which it responds. . . . In the words of a sagacious trainer of animals, we "Arrange all the circumstances of the experiment so that the animal is compelled by the laws of its own nature to do the trick."

The third means is the arrangement of the results of the different possible responses so that desirable ones give satisfaction and undesirable ones, discomfort. By rewards and punishments, natural or designed, parents, teachers, employers and rulers preserve the responses which they approve and stamp out those which they disapprove. The history of the mind's training is in a great measure the history of the elimination of its mistakes." (E. L. Thorndike, *Elements of Psychology*, p. 209.)

## Questions for Study

1. Explain and illustrate by examples from your own experience the laws of contiguity and similarity.
2. Why should the nurse show respect and consideration for the special objects which patients sometimes insist upon having about them in sickness?
3. Mention objects which, through unusual circumstances, have taken on a different aspect to you.
4. What are the secondary laws of association?
5. What can be done to control the associations?
6. Give examples of so-called "fixed ideas" as shown by patients under your observation; examples of "notions." How should the nurse manage such patients?
7. How may the nurse understand something of her patient's associations?
8. Define purpose; delusion; organization.
9. Give instances of unpleasant associations aroused in the patient's mind by thoughtlessness on the part of the nurse.
10. What purpose should be held before the patient's mind?
11. Which one of our five patients shows least organization of associations?
12. Give example of spontaneous and controlled thinking.

## References

Colvin and Bagley, *Human Behaviour*, Chapter 16.
James, William, *Talks on Psychology*, Chapter 9.
Pillsbury, W. B., *Essentials of Psychology*, Chapter 6.

### Questions for Re-education

1. Do I make an effort to organize my association processes?
2. Have I a tendency to "hero worship"?
3. Do I associate undesirable motives with the actions of people I do not like? Are my associations always fair?
4. Have I "rational prejudices"?
5. Am I unduly sentimental in keeping about me trifles of all sorts?
6. Do I unwisely keep letters which have absolutely no active meaning in the present? What helps me to decide which letters and souvenirs to keep?
7. Do I allow my mind to be drawn from a lecture or from study by indulging in analogies which entertain and amuse me?
8. In my study and contemplation of the human body, are my associations free from vulgarity? Has my scientific study increased or lessened my refinement?
9. Is my conversation "scatter-brained"?
10. Am I too "thick" to take in fine stimulating impressions? When I go on a journey, take a walk, go to class, do I get all there is to get?

## CHAPTER X

### ATTENTION AND INTEREST

THE grown-up remembers vividly his first lessons in active attention. Can any one forget learning to "pay attention to the minister and not look around"? Easy enough it was, at first, to look at that dignitary. He caught the eye irresistibly. One could not help gazing at his flowing vestments, so hampering to movement, at his eye-glass tethered to his nose by a black ribbon, at his pursing lips that made all words sound so big and round, at his black, his blinking eyes—but this involuntary attention did not last long. . . . Came the sound of some one arriving late. Swish, swish—tap-tap, tappety-tap—squeak, squeak—oh, *who?* To look around, to see who was committing the sin of tardiness! Attention turned naturally from the pulpit. But someone always leaned down and whispered, "Pay attention to the minister—don't look around." . . . Pennies could not be taken out of the pocket for a walk, handerkchiefs could not be made into limber-legged dolls—nothing, nothing could be done except "pay attention to the minister." If one accomplished this feat—

the mind upon attending to the task in hand for the sake of a particular "remote interest which the effort will serve"[1]—there would be at home that delicious reward, a Surprise. A jack-in-the-box perhaps. Because of that something much to be desired the little mind set itself to conscious effort. "Pay attention to the minister—pay attention—pay attention—pay attention to the minister and don't look around"—the words sung themselves into a kind of song, rhythmically beating through the long hour. . . . And so it was, the growing mind learned to take in something of what the minister said. Interest grew and soon, oh, how very soon—other young persons who did *not* pay attention to the minister were regarded with disapproval. Why, it was fun to listen to him talk—to remember bits for later repetition to grown-ups, and to receive the never-failing reward of something nice out of a pocket. Who cannot recall many such childish experiences, centreing about "learning to pay attention"?

Mr. James says:

"Attention may be divided into kinds in various ways. It is either to

(a) Objects of sense (sensorial attention); or to

(b) Ideal or represented objects (intellectual attention).

It is either

(c) Immediate; or

[1] William James, *Psychology*, pp. 220 and 221.

(d) Derived: immediate, when the topic or stimulus is interesting in itself, without relation to anything else; derived, when it owes its interest to association with some other immediately interesting thing. What I called derived attention has been named 'apperceptive' attention. Furthermore, Attention may be either

(e) Passive, reflex involuntary, effortless; or,

(f) Active and voluntary."

Our interests and purposes, either partially or wholly defined, our instinctive tendencies regulate our attention. We naturally pay attention to the things that interest us, either directly or indirectly. James defines "natively interesting" things as those which are interesting in themselves, to which we give spontaneous attention; "natively uninteresting," things which call forth voluntary attention or attention with effort, and take on interest through proper connections made by training.

"'Ten-*shun!*" The keeper of the mind rings out this thrilling call. He determines *what* the mind shall attend. Shall this object be let into the mind? And another excluded? The keeper of the mind discriminates. Without him education cannot be achieved.

### *The Attention of the Nurse*

1. The nurse may need at times in her work to recall her ultimate aim, her ideal of service. She should recognize certain tasks as a means to

an end. Certain rudimentary duties in which the nurse cannot take active pleasure, take on an interest if she thinks of them as a part of the service which will make her patient well. Thus she may give difficult tasks, monotonous duties, the secondary passive attention[1] essential to good nursing. She will not find anything menial or disagreeable about her service. It is significant that the nurses who enlarge upon the trying features of the profession, do not give to it the highest type of nursing. They cannot develop an interest in anything except the attractive side of caring for the sick. The more definitely the nurse's mind is set upon her ideal, the greater will be her sincere interest in details which many term obnoxious. Eventually, she actually does not encounter such details as distasteful. . . . She performs her tasks therefore with greater serenity. She is unaffected by phases which upset other nurses and make them periodically say they believe they will give up nursing. Every duty takes on interest because it helps to accomplish the end desired.

2. If the nurse's mind is "set" for highest service she will see in the daily round, opportunities which escape the attention of the materially minded nurse. While the minds of all nurses are set, supposedly, for professional tasks when on duty, there is a wide variation in the attention to opportunity of service.

3. The nurse cannot succeed unless she learns

[1] Colvin and Bagley, *Human Behaviour*, p. 61.

to exercise active attention. Her progress depends upon her ability to do things, not for immediate but future results. Her business may be measured by her power to stick to her ideal, her determination to make a reality of her aim. The profession is better off without those nurses who do not know the difference between active and passive attention.

### *The Attention of the Patient*

1. The patient is occupied for the most part during severe illness with passive or spontaneous attention. His pains and aches compel his attention. They have a special interest because they are *his* aches and pains. Disease has distressing power to make things unpleasant. Those it attacks cannot be indifferent to it. . . . Disease often saps the vitality to such an extent that only intense stimuli will rouse even spontaneous attention.

2. In dealing with weak patients do not plan any sort of entertainment which demands active attention. Do not expect him "to give if he gets." Often a patient gets nothing out of entertainment or occupation because he is too weak to bring anything to it.

Spontaneous attention is given to rhythm—this is one of the reasons why music may be used with curative effects as well as for entertainment. Listening to certain kinds of music requires no

active effort, consequently the patient suffers no exhaustion.

In interesting the patient, even when he is getting strong, work always upon the principle that he will give his attention most readily first to something that is "natively interesting." Stimulate desirable instincts and thus secure voluntary attention toward definite ends and active attention will follow readily.

In general it may be said that the patient's power of active attention is to be considered weak so long as he is a patient. He cannot control his attention as in health. "What is the matter with me?" he grumbles. "I can't keep my mind on this." Even in listening to someone tell a story, the patient's mind may refuse to follow. Short sentences and definite directions are always to be preferred in speaking to patients. The patient is always more interested in short snappy incidents related by his callers than by any long narration. In convalescence, when the patient is well enough for occupation, the nurse never forgets that the patient's ability to give any degree of active attention comes back gradually and, at best, cannot be regarded as equal to that of the individual in health. Even when reading aloud to a patient, this fact must not be disregarded. A patient has to be feeling very well indeed if he can keep his mind upon a story of any great length. Usually he hears the first part—the rest is lost in a blur. If the mere sound of someone reading aloud is

soothing, let it go on—but do not expect the patient to tell much about what you have been reading. It is just as well not to embarrass him by asking him anything about it. If he has anything to say, he will say it on his own initiative.

3. Do not lay before the patient something which does not connect itself in any way with what he is already interested in—or with his personal welfare. The nurse may use wisely the hint given by James that if the new is associated with the old in some effective way, interest follows naturally from point to point. Our patient, Mrs. O'Brien, will be much more easily induced to learn to knit if she sees that her knitting-needles have some connection with the well-being of her family. Warm knitted garments for her children will be of far more interest to her than fantastic knitted ornaments. Pierre La Vaque looks upon the tools of a new craft with different eyes when he sees in them a means of earning a livelihood.

Difficult, indeed, is the task of bringing something new into a life that is slowly ebbing away and yet, a patient like our Dr. Sanderson may be saved in no other way from utter despondency. Active attention to something wholesome and diverting—not requiring too much concentration can make a great difference in the remaining months or years of a patient's life. In such an instance, build upon the patient's old delights and create a new field of interest.

4. The nurse needs to remember the natural

rhythmic character of attention. The rhythm of the patient's attention is not extended. In planning the amusement of patients, the nurse may learn something of skilful management in holding the attention from the lecturer who "holds his audience." It is noticeable that he knows just when to introduce his anecdotes, when to use the blackboard or pictures. If the rhythm of attention is not taken into account, there comes over the audience a general rustling of programs, whispered comments, shiftings about—all indicating a lack of concentration. Every professional manager of amusement programs knows the pulse of the audience's attention. What will bring back the keen edge of interest? This is the entertainer's problem. Besides taking the rhythm of attention into account in amusement plans, the nurse may need to consider it when she is trying to get a patient to carry out some new treatment or to keep his mind upon certain exercises. Contrast, movement, and novelty serve well in bringing the mind back to the thing in hand. At times an unpleasant stimulus is effective where radical measures must be taken for the patient's own good.

The nurse should feel a responsibility in aiding the patient to sustain attention when necessary. She must see to it that the patient does not "let up" when he is paying attention to the execution of the doctor's orders. Often, in carrying out a nursing procedure, the patient will "play for time," like a veritable child, trying to avoid giving his

attention to some thing he dreads. He makes foolish requests, trying to "put off" a treatment; the nurse will be quick to recognize dilly-dallying of this nature. Certainly she will not be gullible enough to allow her own attention to be diverted from the thing in hand.

5. The nurse will remember that it takes the patient longer to "get started" than the individual in health. He should always be helped. If left to himself, he may use up all his strength in preliminaries. Everything that a patient needs must be ready before he takes a task or occupation in hand. Waiting, propped up in position, while the nurse hurries hither and thither after forgotten articles, wears the patient out. Such waiting may even take away his desire to give his attention to the particular thing planned, or, make a simple procedure such as brushing his teeth, seem very trying. Any commotion before taking the patient out for a sunning should be avoided.

"I like to sit on the porch," the patient says, "but it is getting there that I dread."

The nurse should make getting out on the porch so easy that the patient has no sense of strain. All changes should be made as quietly and easily as possible. Every little detail, every move, should be planned beforehand so that the patient feels no reluctance, no distaste about "getting started."

In preparing the patient to attend to a particular thing, the nurse should be careful to get him into

the bodily position that will help, not hinder. If it is only taking a drink of water, or using a gargle, the nurse should see that he is helped to the correct position. If the patient wants to write a message, he cannot give his attention to it easily if he is left to shift for himself in getting ready to write. Certainly he cannot enjoy eating if he is not in a good position. While it is true that patients are often benefitted by helping themselves, the nurse should not neglect to assist patients to advantageous positions so long as they are under her care. "Getting ready" may be a joint affair, so that the patient makes all the exertion that is good for him while the nurse gives adequate assistance.

In teaching a patient a new occupation, it is best that he should at first be apart from other patients. "Getting started," giving attention to the new is always easier for him if he has a quiet corner to himself.

6. Patients naturally vary a great deal in the power to "stick at things" after they get started. Here the developed and the undeveloped mind must be taken into account as well as the degree of the patient's strength and interest. Something besides mere fatigue and a low ebb of interest makes itself felt. Sometimes it is very hard to induce the patient to keep up his part of getting well. He gets tired of certain treatments—he does not realize the importance of his own efforts. He may lose faith—he thinks perhaps he would

like to try another hospital or physician. He cannot keep his attention upon the routine outlined for him. Or, in learning to do something with his hands, he may show a disposition to look out of the window, to gaze at the way other patients are working. If he encounters difficulties, he usually pushes the occupation aside, even if it is something merely for his entertainment. The pride that many people show in health in keeping at a thing until they master it, is lacking in the sick. A developed mind may not show the same characteristics under stress of sickness as in health. However, the trained mind approaches its task with less resistance, and, under most circumstances, gives it up less quickly than the undeveloped mind. In teaching occupation, the nurse should not fail to encourage, to stimulate patients who are well enough to make the effort, to feel a certain pride in not giving up. The tendency to distraction is a matter of importance in influencing the patient to give up. The nurse may do much in obviating distractions. It is better not to have the patient encounter them, since the effect is often beyond the control.

7. What, in general, will the patient attend?

Many things must be measured by the nurse in considering the *nature* of the patient's attention. First of all, he is most likely to give attention to that which will make him more comfortable. Little *present* things take on tremendous importance Do not expect the patient to fix his mind

easily upon the remote; he must be helped to do this when it is for his own good. The patient's heredity sometimes controls his attention unexpectedly. Other factors—the extent of his education, his idea of duty, his particular "notions" play a part in determining the *nature* of his attention. Naturally, the influence of certain drugs which dull or quicken the power of attention must be taken into account. The natural instinctive tendencies to attend are weakened in illness but they control to a large degree the nature of the patient's attention. (See Definition "Instinctive *attention.*")

8. The nurse should not make the mistake of asking the patient to pay attention to what is really the nurse's duty. For example, the patient should not be expected to hold the electric-light bulb when the nurse is shaving a part of the body for operation, or to render assistance during a dressing. There are exceptional instances of course when it can do no harm to enlist the patient's interest and help at such times. Rolling up the outside bandage again is a bit of help the patient often enjoys. However, as a general thing, the patient should be entirely relaxed during the preparation for an operation or while a dressing is going on. The ancient Greeks recognized the harm that may result from too much attention on the part of the patient to nursing procedures. Hippocrates, for example, specifies in his instructions for bathing:

"If the patient is not bathed properly, he may be hurt thereby in no inconsiderable degree. . . . The person who takes the bath should do nothing for himself, but others pour the water upon him and rub him . . ."[1]

## Definitions

"*The Narrowness of Consciousness.*—One of the most extraordinary facts of our life is that, although we are besieged at every moment by impressions from our whole sensory surface, we notice so very small a part of them. The sum total of our impressions never enters into our *experience*, consciously so called, which runs through this sum total like a tiny rill through a broad flowery mead. Yet the physical impressions which do not count are *there* as much as those which do, and effect our sense-organs just as energetically. Why they fail to pierce the mind is a mystery, which is only named and not explained when we invoke . . . 'the narrowness of consciousness,' as its ground." (William James, *Psychology*, p. 217.)

"*Voluntary attention.*—Dr. Carpenter speaks of launching himself by a determined effort. This effort characterizes what we call *active* or *voluntary attention*. . . . *There is no such thing as voluntary attention sustained for more than a few seconds at a time.* What is called sustained voluntary attention is a repetition of successive efforts which bring the topic back to mind. The topic once brought back, if a congenial one, *develops*. . . . *No one can possibly attend continuously to an object that does not change.*" (William James, *Psychology*, p. 224.)

[1] Nutting and Dock, *History of Nursing*, Vol. I.

"Instinctive attention.—Some of the more important instinctive tendencies to attend, other things being equal to:

(1) Moving objects rather than still objects.

(2) Other human beings and living animals rather than plants or inanimate objects.

(3) Clear rather than obscure or indefinite objects.

(4) Intense rather than weak stimuli.

(5) Novel rather than familiar objects (unless the latter have special advantages).

(6) Pleasurable rather than painful stimuli.

(7) Expected rather than unexpected stimuli. (E. L. Thorndike, *Elements of Psychology*, p. 310.)

## Questions for Study

1. What factors influence attention? How does each one of these factors make itself felt in the attention of Pierre La Vaque?

2. What is the fundamental principle of human progress?

3. Distinguish between active and passive attention? To what do we naturally give spontaneous attention?

4. How is secondary passive attention developed?

5. What is meant by the expression, "His mind is set"? Why does an individual jump at the sound of his own alarm clock and disregard the whistle that calls his neighbour to work?

6. Can you relate a childish experience in learning to give active attention?

7. What is meant by the expressions, "natively interesting" and "natively uninteresting"? Mention

things which are "natively interesting" to the majority of people you call your friends.

8. Specify different interests you have noted in various nationalities. Mention marked racial interests of the black race; the red race; the yellow race.

9. Mention some notable accomplishments resulting from the active interests of nations.

10. Can you think of any one who gave active interest to a particular subject, solely for the benefit of generations to come?

11. What points does the nurse need to take into account in considering the patient's attention? To what does the patient give instructive attention?

12. Give some examples of undue demands upon the patient's attention.

13. Have you noticed particular instances when patients were hampered in giving attention by disadvantageous bodily positions?

14. Tell how, in "making things interesting" to Mrs. Telford Worthington, you would make use of the psychological hint that if the new is associated with the old in an effective way, interest follows naturally from point to point?

15. How may Isabel Terry learn to waste less time "warming up"?

16. What do we mean when we say that our thoughts are "wool-gathering"? Express it in psychological terms.

17. Bessie McCaskell is inclined to gaze out of the window during class at clouds in the shape of witches on broom-sticks and so on—what means should she take to sustain interest in the recitation?

18. Tell how you would explain to Pierre La Vaque in words that he can understand that he can develop

power of concentration just as he has developed the power to use his artificial arm.

19. Why should the first stages of an idea be made particularly clear and concise to the patient?

20. What is the secret of sustained attention?

21. Explain the term "span of attention." Why is it important to organize and to relate all parts of instruction in getting a patient to help himself?

22. Review the steps in bringing about replacement of ideas.

23. How should you manœuvre to wedge in a new interest in the mind of Dr. Sanderson? Of E. J. Andrews?

24. How may you distinguish between lack of interest and fatigue of mind?

25. How may you make E. J. Andrews lose his fear of old age?

## References

Colvin and Bagley. *Human Behaviour*, Chapter 4.

Pillsbury, W. B. *Essentials of Psychology*, Chapter 5.

James, William. *Talks on Psychology*, Chapters 10 and 11.

## Questions for Re-education

1. Do I indicate by my bodily attitude that I am giving attention when people address me? Does my attitude denote distraction when other people relate their experiences? Do I realize the professional duty of looking my superiors in the eye when I am receiving instructions? Do I habitually look into the eyes of those who are speaking to me? Do I look at people

when I talk to them—even the clerk who receives my order? When I am in a drawing-room do I appear more interested in the pictures on the walls and the motif of decoration than in my hostess?

2. Is my education such that I give attention to artistic things? Can I maintain fairly that my interests are finer than those of the average girl?

3. In what direct ways does my heredity influence the nature of my attention?

4. By what interests do my social or individual ideals reveal themselves?

5. What have I ever accomplished that showed an active interest in the welfare of others? Have I ever made a sacrifice for a remote end?

6. Do I impress others as being indifferent to other people's interests?

7. Am I easily distracted from the things to which my duty as a nurse demands that I should give my active attention?

8. In what ways may I broaden my interests?

9. Have I so far in my life wasted time in "warming up"?

10. Have I pride in mastering difficulties? Do I give up more quickly than most girls when encountering difficulties?

11. Do I give the impression of strength which comes from a highly developed power of giving active attention, or of weakness which results from lack of power to concentrate?

12. What particular things have I been interested in since childhood? Am I inclined to drift along, accepting other people's ideas of what is worth while or do I find out for myself what a thing is like?

# CHAPTER XI

## MEMORY

"Evidently our brain contains something akin both to a photographic plate and a phonographic cylinder and many things of the same kind not yet discovered; not a sight or a sound or a smell is lost; not a taste or a feeling or an emotion. Unconscious memory records them all, without our even heeding what goes on around us beyond the things that attract our immediate interest and attention."—GEORGE DU MAURIER in *Peter Ibbetson.*

"I WISH I could remember things!"

On every hand we hear this cry. The husband comes home, perturbed, as he sees his wife at the door, because he has forgotten something she told him she simply cannot get along without. The wife is ashamed when her husband pulls out of the drawer, the socks she has not remembered to darn. The children dash in from school, disgusted because they have failed in their tests—they "couldn't remember anything." . . . Every home in its little round is beset by forgetfulness. The streets are full of hurrying people who have forgotten something. Offices ring with indignation over

forgotten details. . . . "I wish I could remember things!" People go on saying over and over, as if the key to remembering might be tucked away, unattainable except by the favoured few.

"The art of remembering is the art of thinking," James expresses it practically. "When we wish to fix a new thing in our mind, our conscious effort should not be so much to *impress* and retain it as to *connect* it with something else already there. The connecting *is* the thinking, and if we attend clearly to the connection, the connected thing will certainly be likely to remain within recall. The 'secret of a good memory' is thus the secret of forming diverse and multiple associations with every fact we care to retain. But this forming of associations with a fact,—what is it but thinking *about* the fact as much as possible? Briefly, then, of two men with the same outward experiences, *the one who thinks over his experiences most* and weaves them into the most systematic relations with each other, will be the one with the best memory. . . . There can be no improvement of the general or elementary faculty of memory; there can only be improvement of our memory for special systems of associated things; and this latter improvement is due to the way in which the things in question are woven into association with each other in the mind. . . . The more other facts a fact is associated with in the mind, the better possession of it our memory retains. . . ."

Whether one has a good memory or not, depends, as psychologists designate, *upon the number and persistency of associations.* To dismiss mem-

ory by saying, "This is all there is to it," would be to pass over the many interesting things which have been said upon the subject. However we get the gist of the so-called memory secret in a few words. We may amplify at length but we cannot add anything to the working law of "how to remember things."

Most of us know, in a general way, the psychological facts concerning memory, and yet we go on crying, "How I wish I could remember things!" as hopelessly as if we had no knowledge of how a good memory might be acquired. We know the laws, but we do not apply them. Now there is no "catch" about the practical way to acquire a good memory. But there is *work*. There's the rub! Eternal human resistance—otherwise "pure laziness" keeps us from developing useful reliable memories. We can't wave a wand over our indolent brains and transform them. Disconnected ideas can't be "magicked" into relationships. Brain paths cannot be created and organized by rubbing our heads. So we go on forgetting. . . . Let us admit frankly that "it is too much trouble" to train our memory. We excuse ourselves easily by saying we have "naturally a poor memory," although we know well enough that even if our elementary faculty—our retentivity—is weak, at least we can improve our memory by making use of the suggested means. We *can* remember if we will—that is, if we make up our minds to pay attention to the *organization* of

associations. It is a fact that this power of organization has to be built up by effort, more or less painstaking. We are not likely to remember things our minds cannot explain. If we can explain a thing in a variety of ways, we are sure that it is in our minds to stay. The setting up of connections that insure a good memory, demands persistent care.

"I *tried* to remember!" If the fruitless effort is analyzed, the reason for failure is accounted for usually by the fact that no *connections* were made in the mind concerning the thing to be remembered. The mere wishing to remember a thing, or even making the effort to remember, will remain a hit-or-miss process, unless the necessary connections are set up. Trying to remember by repetition, or by stamping a thing vividly upon the mind, can never take the place of forming associations that will hold. Impressing an object upon the mind in order to retain it, is only the preliminary process. The nervous system must receive its stamp of an experience—and the stronger the impression the better—but this stamp is not enough.

We have two questions to answer when we are trying to remember something, *i. e.*, "How can I stamp this upon my mind?" and "With what can I connect this in my mind?" The use of these questions as a means of getting the mind down to its task, is helpful. More than any other method it will train the mind to systematic effort. Asking one's self these two questions, time after time, until they become a part of the memory process.

eliminates the indefiniteness that accounts for so many poor memories.

Psychologists offer well-tried rules concerning memory. In answer to the first question, "How can I stamp this upon my mind?" the methods most generally mentioned are, briefly, as follows:

1. By repeating a thing over and over.
2. By giving active attention; accurate observation.
3. By making a thing vivid to the mind.
4. By following tested technical methods of memorizing.

Each individual must answer the second question, "With what can I connect this in my mind?" according to his stock of ideas. Nothing more practical has been set forth concerning memory, than the fact that "the more one knows, the easier it is to remember."[1]

The importance of the nurse's work makes it imperative that she should be able to remember facts without error. Her duties often require the immediate application of knowledge—there is no time to see if she is right by consulting a reference book. She must *know* what to do in an emergency and she must *know that she knows*. Her nursing knowledge must be logically classified, so that she has no uneasiness about being able to remember things. To forget in a crisis—what greater professional humiliation can a nurse experience?

[1] Pillsbury, W. B., *Essentials of Psychology*, p. 212.

To forget "little things" habitually brands a nurse as inefficient and unreliable. She must be very sure of herself in every professional demand upon her memory, whether it be remembering what to administer for corrosive sublimate poisoning or what kind of tea her patient likes to have. Intelligent behaviour upon her part demands that she should remember psychological principles at every turn.

How may the nurse be sure that she knows?[1]

1. Students going over lessons together rely upon the common test technically called "the method of retained members." One girl holds the book and "plays teacher." If the other girls can answer her questions according to the text, either word for word, or in words equivalent in meaning, they say that they "know the lesson." It is always noticeable that some students are able to rattle off, parrot-like, definitions and formulas with very showy effect, but fail in their practical work to demonstrate that they really know what they so glibly recite. To be able to state clearly in her own words what she has been studying, is an important test of memory.

2. The "test for right associates" is an easy method for the nurse to apply. For example, in learning her vocabulary of professional terms, she can write the everyday expressions and follow with the professional—nose-bleed—epistaxis, ringing in the ears—tinnitus, etc.

[1] Colvin and Bagley, *Human Behaviour*, pp. 249 *et seq.*

3. If the nurse is learning operating instruments, she is conscious of a test of memory, when an instrument is presented to her for recognition, or, when she is sent to the cabinet for a particular instrument. She does not know the instrument if she cannot select it from others. Young nurses frequently become confused in their first practical work, by failing to recognize something they have studied. Even going over things in the demonstration room is not always enough. If the nurse recognizes the things about the hospital as those she has studied about, if she is sure of what to do with them, of how to use them in particular situations—then she may be certain that she knows them. The nurse is fortunate in having her knowledge put to this practical "*test of* recognition" very soon in her training. This method is frequently used in the classroom also, so that the nurse has a double test. Sometimes, in the excitement of the practical experience, things do not look at all as they looked in the classroom and the nurse fails to recognize them as the same. It is noticeable that those who observe closely and accurately, meet best the test of recognition.

4. "*The method of reconstruction*" is an important one for the nurse to use since it involves memory for order and arrangement, which play such a part in her world. For example the nurse learns the order in which certain instruments are to be used for an operation. She lays them one by one in the correct arrangement. If they are disar-

ranged, she can put them back in order. Thus she meets the test of reconstruction. She will do well to put herself to this test in the many procedures involving arrangement.

5. In the stress of training, the nurse is often distressed, because she cannot recall something she thought she knew perfectly when she went over it in class. She never expected to forget the bones of the body—and here she is, three weeks later, having to learn most of them again in readiness for a test. However, she is encouraged by the fact that she learns them more readily—her memory is tested by the length of time the re-learning takes. "*The saving method*" serves to prove that nothing is actually wiped out of the mind. Let the discouraged student take heart by the fact that she does not actually "have to learn it *all* over again."

6. The nurse cannot rightly determine whether she has a reliable memory, unless she includes in her tests, the "test for permanent memory." She must be sure that she knows a thing so well that she can bring it to mind no matter how long the interval between the time of learning it and the need of remembering. She will soon realize that the great amount of new material she learns in training can never be retained unless she goes over it again and again. She can put herself to unexpected tests, just as her instructors may do,—that is, without preliminary study, she can try out her memory upon some subject studied weeks or months before. Such constant going over

knowledge, makes the nurse sure of herself, as nothing else can.

How may the nurse guard against "falsification of memory"?[1]

Many times the nurse is disturbed because, in reporting something as faithfully as she could, she realizes later that she has stated details that did not actually occur. She has not meant to falsify and yet it is proved that her report cannot be relied upon. So many things happen in the busy life of the nurse, it is very easy to confuse experiences. This is particularly true, if, to the nurse, "all patients are alike." Her observations are not clear-cut. There is nothing in her impressions of her patients, that makes the experiences of each patient stand out in distinctive fashion. As soon as the nurse begins to consider each patient as worthy of individual study, she will remember easily the particular experiences that cluster about him. She will not so often confuse what happened to one patient with what happened to another. There is no surer way to eliminate such falsification of details than by developing the ability to "take in" a patient and all that he does as a human being separate from other patients. In studying the different personalities of patients, the most insignificant details will cluster in orderly fashion in the nurse's memory. As a help in setting up this habit of mental personality notes, the nurse will find it helpful, and fascinating as well,

[1] Colvin and Bagley, *Human Behaviour*, p. 262.

to keep a note-book, "Studies of My Patients." Even a few such studies, worked out carefully in detail, will tend to make the memory of experiences truer to fact.

A nurse reporting a case of arsenic poisoning, filled in, without realizing, with details of a typical case studied carefully in class. Unless the nurse is very careful, she will be doing such things constantly. She will state as a fact, what she knows is "usually the case." . . . If the nurse's reports are of real value, they must be confined absolutely to truth. There must be no "filling in." As the nurse's experience broadens, she will look more for *exceptions* than for *typical* cases. She will also be less prone to mix what she reads and studies about patients with what she actually sees.

The nurse needs to stand her ground when she is talking over accidents or emergencies, happenings of various kinds in professional work. Unless she is very certain of her own original impressions, she will take on suggestions from the "leading" questions addressed to her, or from the speculations of others. "Did the patient seem a little more restless than usual after his dressing?" The nurse hesitates. "Perhaps so," she speculates. The next time she speaks of the circumstance, she says, quite unconsciously, "The patient was more restless than usual after his dressing." The dangers of suggestions of this sort are obvious.

The nurse's word is always a matter of importance. It is her professional duty to see to it that

her statements are free from falsifications of memory.

If the nurse sees in herself the tendency to enlarge upon fact in order to "make a good story" as Isabel Terry does, she should hold herself rigidly to facts. Embellishments which "add" to the interest of a narrative, are never worth while, since the practice undermines the nurse's integrity. Deliberate dressing up of an experience, leads to a more or less hazy memory of what really did happen,—the narrator reaches the point where it is impossible to state the actual facts. Nurses who indulge in telling "tall stories" for the amusement of their friends and patients, are much more susceptible to the influences that bring about unconscious falsification of details. When a lively "story-teller" first resolves to stick to fact she may feel a bit shorn of her power of interesting people, but let her once take pride in expressing herself well, and she will realize that it is not so much what she says as the way she says it, that counts. She will not feel the need of the "made-up" bits, once she masters the art of putting words together in adroit original fashion.

"I can't remember everything!" This is the petulant excuse we hear very often for forgetting. We are not, of course, expected "to remember everything," *only the things that are important in helping us to adjust ourselves to our environment.* The art of forgetting is a process demanding careful discrimination.

The nurse should train herself to forget unpleasant experiences, when they have no useful place in memory. It is a mistake to brood over unfortunate happenings, tragic occurrences that occur in her nursing experience. The profession has its bright and happy side; if the nurse pays attention to this side, she can the more easily eliminate the gloomy aspect from memory. It is a decided advantage to the nurse to be able to go through a trying experience with poise—to "shake off" the effect. It is better for her physically as well as mentally, if she does not let unpleasant things "sink in."

Concerning the patient's memory, the nurse will have need of the following points of guidance:

1. When it is necessary to question a patient concerning a past experience, the nurse will avoid asking "leading questions." Her technic of questioning is needed. Any questions used in such instances, should be wholly without suggestion. The patient quickly seizes upon the suggestions he gleans from the doctor's and the nurse's questions and weaves much into his experiences that never existed. This may be done quite unconsciously with the patient as with the individual in health. The patient is perhaps more susceptible to suggestion, particularly when such suggestions pertain to his aches and pains. He is like the farmer who sent for every patent medicine he saw advertised, believing, after reading the various symptoms, that he had them all.

2. Nurses and physicians learn to take many statements from the patient "with a grain of salt." The patient has a proverbially unreliable memory. He thinks he is telling the truth, but his illness makes it impossible for him to remember accurately. Patients will vow that they "haven't slept a wink," and believe that they are giving an exact account of the night. In general, patients have no clear recollection of what happens during their illness. They remember in snatches. Their sickness is a blurred conglomeration of impressions. Sometimes they cannot remember anything except their convalescence. Events preceding their illness may be entirely lost, as well as the experiences during disease. If a patient suffers an emotional shock, all memory of recent events may be obliterated for the time being as entirely as if he had had a fall or a blow upon the head.

3. The nurse needs to be a sort of memory-prop to her patient in little things. It is difficult for him to recall things—even names of common objects sometimes. If the nurse has never been sick herself, she can understand in a measure how the patient's memory is affected, by comparing it with the way she feels when she is very much fatigued—"too tired to think." At such times she finds herself mixing the names of things and people, or, in extreme instances, failing entirely to recall what she really knows. With rest, things come back. With the patient, his memory is blocked by disease—he cannot recall things

always at will. Remembering is a painful effort as a rule. So the nurse will save him whenever possible the exertion of getting the right word or of calling a thing to mind. Certainly, the patient should never feel that he has any responsibility about remembering procedures that are the nurse's direct concern. The nurse should feel humiliated in the extreme if she has to be reminded by the patient himself of his needs. If the patient "has to remember things," he cannot relax as he should. In considering memory, the nurse should work for the absolute relaxation of the patient's mind.

4. In dealing with patients who have lost all memory through some injury, the nurse can be of use in the work of restoring memory. Principally, she will utilize the influence of old associations.

5. During sickness, old and so-called "forgotten" experiences, often play an unexpected part. Memory is sometimes persistent to an inexplicable degree. Some long-ago impression, not recalled by the patient for years, may reassert itself and affect his attitude. Especially in delirium, "forgotten" things make themselves felt. For example, a patient refused during his delirium to allow a nurse with red hair to stay in the room. He called her "Blab-tale" and showed a persistent distrust of her. No one could account for his attitude, until, during convalescence, the patient was able to dig up from childish experi-

ences, a long "forgotten" red-headed playmate who "told on" him once at school when he was eating candy behind his geography. Past experiences of this sort explain many caprices and antipathies of delirious patients. The mind in illness makes strange associations. . . . The talk of delirious patients is often filled with allusions to "forgotten" things. Patients often use language quite foreign to them in health—obscene expressions, provincial phrases, belonging to the long ago. Even patients who are not delirious sometimes forget their more recently acquired vocabularies and revert to an earlier way of talking. An acquired accent is usually entirely lost during illness, and taken on again when the patient begins to get well.

6. The nurse wisely keeps silent about the wanderings of the delirious mind. Patients often ask, "What did I say when I was out of my head?" and display considerable curiosity about their ravings. However, the nurse is usually pursuing the best course by answering casually that delirious patients seldom say anything connected or important. If she tells the patient what he has said she risks upsetting him by reviving undesirable memories. Needless to say, the nurse never makes the wanderings of her delirious patients a subject of jest to other people. Nothing the patient says in delirium should be talked about, unless it has a possible bearing upon some anxiety that may be removed.

7. In teaching a patient an occupation, the use of an artificial limb, or a régime to be followed in the absence of the nurse, he may be tested for memory of the given instruction, after the same methods as those used for persons in health, except that he must not be expected to retain nor to recall so easily. Moreover, the patient should be given only short tests at a time.

## Definitions

"*Memory and the Law of Association.*—The terms memory and remember are used to refer to (1) the revival of a mental fact in imagination, (2) the revival of a fact plus the feeling of its having been in one's experience at some time in the past, (3) the revival of the appropriate mental fact in response to a situation, and (4) the revival of a movement or set of movements. . . . Goodness of memory depends upon the permanence of impressions, the permanence of connections, their number and their nature or arrangement. . . ." (E. L. Thorndike, *Elements of Psychology*, p. 255.)

"*Recognition.*—If, however, a phenomenon be met with too often, and with too great a variety of contexts, although its image is retained and reproduced with correspondingly great facility, it fails to come up with any one particular setting, and the projection of it backwards to a particular past that consequently does not come about. We *recognize* but do not *remember* it—its associates form too confused a cloud." . . . (William James, *Psychology*, p. 299.)

"*Analysis of the Phenomenon of Memory.*—Memory

proper, or secondary as it might be styled, is the knowledge of a former state of mind after it has already once dropped from consciousness; or rather it is the knowledge of an event, or fact, of which meantime we have not been thinking, with the additional consciousness that we have thought or experienced it before. . . ." (William James, *Psychology*, p. 287.)

"*Retention and Recall.*—Such being the phenomenon of memory . . . can we see how it comes to pass? Can we lay bare its causes?

Its complete exercise presupposes two things:

(1) The *retention* of the remembered fact; and

(2) Its *reminiscence*, *recollection*, *reproduction*, or *recall*. Now the cause both of retention and of recollection is the law of habit in the nervous system, working as it does in the 'association of ideas.'

"*Association explains Recall.*—Associationists have long explained *recollection* by association. . . . In short, we make search in our memory for a forgotten idea, just as we rummage our house for a lost object. In both cases we visit what seems to us the probable *neighbourhood* of that which we miss. We turn over the things under which, or within which, or alongside of which, it may possibly be; and if it lies near them, it soon comes to view. But these matters, in the case of a mental object sought, are nothing but its *associates*. The machinery of recall is thus the same as the machinery of association, and the machinery of association, as we know is nothing but the elementary law of habit in the nerve-centres." (William James, *Psychology*, pp. 289 and 299.)

## Questions for Study

1. How does memory differ from perception, false perception, and imagination?

2. Give an example of recognition without recall.

3. Give an example of recall without recognition.

4. Can you give an example from your own experience of recollection without recognition?

5. What are the disadvantages of rote learning? What is the difference between rote memory and logical memory?

6. Can you repeat a jingle you learned when you were a child? Why is it possible for you to recall it when you have not gone over it in your mind for years?

7. Describe memory from the standpoint of the nervous system.

8. How may you learn to be sure of recalling things without error?

9. Upon what does retention depend?

10. Upon what does recall depend?

11. What principle stands above all special methods of memory?

12. What is the explanation of the usual "poor memory"?

13. What two questions may we ask ourselves when we are trying to remember something? Why does asking these questions help us to remember?

14. What is the best memory system?

15. Mention five memory tests, which help us to determine whether we know things.

16. How will you test Pierre La Vaque to find whether he remembers the instructions concerning the use of his artificial arm?

17. Give some examples drawn from your own experience of falsification of memory.

18. Have you noted the influence of so-called "forgotten" experiences in caring for the sick?

18. What does George du Maurier mean by "unconscious memory"?

19. Why is it important that the nurse should have a good memory? Do you think any one who has a poor memory can become a good nurse?

20. What effect has fatigue upon memory? Why is it unwise from the patient's standpoint for a nurse to work to the point of exhaustion?

21. What can be done to improve one's retentivity?

22. What is forgetfulness? What goes on in the nervous system when we forget?

23. Explain paramnesia.

## References

Pillsbury, W. B. *Essentials of Psychology.* Chapter 8.

Colvin and Bagley. *Human Behaviour.* Chapter 14.

James, William. *Talks on Psychology.* Chapter 12.

James, William. *Psychology, Briefer Course.* Chapter 18.

## Questions for Re-education

1. Is my "native retentiveness" strong or weak?

2. Have I ever done anything to improve my memory?

3. Have I a definite idea of how to go about improving my memory?

3. Is it often a fact that I cannot remember accurately because I have not observed carefully?

5. Do I know how to apply memory tests?

6. Have I a tendency to depend upon rote learning?

7. Do I enjoy telling "big stories"? Why should I stop doing this? Need my stories lose interest if I do not embellish them with false detail? Do I know how to prevent this?

8. What is the value of a good memory to me as a nurse?

9. When has my memory failed me in an emergency?

10. Am I inclined to talk about the sayings of delirious patients?

## CHAPTER XII

### HOW TO STUDY

A RÉSUMÉ of psychological laws and hints concerning study will help the nurse to go about learning in a practical way.

1. Recognize the principle of natural resistance as applied to study. Get the whip-hand.

2. Select the place where it is easiest for you to study. After your habit of study is fully formed, environment will not make much, if any, difference to you.

3. Keep before you your resolution to develop a new and thoroughly scientific method of studying.

4. Don't stop to think whether the subject in hand is "interesting" or not. Is it necessary? Will it help you in your adjustments?

5. Be thrifty with your time. The high cost of study can be considerably lowered by wasting less time "warming up" and turning to this and that distraction.

6. Make a bayonet attack. Think of yourself as aggressive. You are going in for mastery of the subject.

7. Establish a "tempo" of study. The speed-

ometer of your mind should be kept to the rate that is best *for you individually*. If you study too slowly, you will find it harder to resist distractions —but the rate should be slow enough so that the material can sink in, slow enough so that proper associations can be formed. If you study too fast, you fall into the error of depending upon rote learning; you get strong associations only of the things directly preceding and succeeding—you have no time to think out the statements you are repeating. Naturally, you can study some things faster than others.

8. Get out of the way of thinking of your subject as enclosed between book covers. Train your mind to bring outside associations to the printed page.

9. Make over as often as possible the material you are studying, into your own way of talking. If you haven't words enough in your vocabulary for this making-over process, go about enlarging your vocabulary. Be very sure that you use the *right* word—the meaning must be equivalent.

10. Search in your own experience for examples of principles. Do not be content with examples given in the text-books—add your own. Be sure these examples illustrate the point in question. If they are pat, they will help you more than anything else in remembering principles.

11. Follow a routine way of going over a lesson or a subject:[1]

[1] Colvin and Bagley, *Human Behaviour*, p. 293.

12. Keep up your concentration so that the last part of the material is impressed as deeply upon your mind as the first.

13. *Never pass over a word you do not understand.* It is not enough to "look it up later on." Many misinterpretations of the whole material may occur from ignorance concerning certain words. Have your dictionary in a convenient place so that you will not have to overcome so much resistance in hunting up the word. Word meanings and discriminations should receive the most careful attention. Know the correct pronunciations as well as the meaning of words.

14. If you "can't get any sense out of the lesson," try to find out wherein your preliminary knowledge is deficient.

15. Do not confine yourself to studying only when you have a book before you. The mind once trained, will take pleasure in learning from every source. Learning is left off, only when life is done.

16. Keeping note-books on various subjects develops the power of "putting together things that belong together." If rightly kept, such books will not be mere props. Original thought as well as exactness of expression can be developed by jotting down ideas and observations.

17. Aspire to the aristocracy of mind that will lift you above the commonplace. Be willing to *work* to achieve it.

## Quotations

" . . . The stock methods of memorizing: Repetition, Concentration, and Recall. Repetition strengthens both the impressions and the connection between them and is easy and natural, but it is somewhat wasteful of time. Concentration, or prolonged attention to the fact to be remembered, strengthens the impressions and the connections between them and saves time, but at the expense of effort. Recall (*i.e.*, the expression *from within* of the fact to be remembered, after one or more impressions of it from without) gains the extra advantage of forming the connection in the way in which it will be required to act later and it is conceded to be the best method of the three.

"The general permanence of impressions and connections, the mere retentiveness of the mind, is decided largely by original capacity and the general conditions of bodily health. The permanence of any particular impression or connection depends also upon the degree of attention given to it, its vividness, and the frequency of its repetition. The number of connections depends upon experience or training. The choice of logical and useful connections depends upon experience as directed by the capacity to see the essential elements in situations." (E. L. Thorndike, *Elements of Psychology*, p. 258.)

" . . . You might read all the books in the British Museum (if you could live long enough), and remain an utterly 'illiterate,' uneducated person; but . . . if you read ten pages of a good book, letter by letter—that is to say, with real accuracy—you are forever-

more in some measure an educated person. The entire difference between education and non-education (as regards the merely intellectual part of it) consists in this accuracy. A well-educated gentleman may not know many languages—may not be able to speak any but his own—may have read very few books. But whatever he knows, he knows precisely; whatever word he pronounces, he pronounces rightly; above all, he is learned in the *peerage* of words; knows the words of true descent and ancient blood, at a glance, from words of modern *canaille*. . . . An ordinarily clever and sensible seaman will be able to make his way ashore at most ports; yet he has only to speak a sentence of any language to be known for an illiterate person; so also the accent, or turn of expression of a single sentence, will at once mark a scholar." (JOHN RUSKIN in *Kings' Treasuries*.)

"Books . . . by great readers, great statesmen, and great thinkers . . . are all at your choice; and Life is short. . . . Will you go and gossip with your housemaid, or your stable-boy, when you may talk with queens and kings . . . when all the while this eternal court is open to you with its society, wide as the world, multitudinous as its days, the chosen, and the mighty, of every time and place?" (JOHN RUSKIN in *Kings' Treasuries*.)

## QUESTIONS FOR STUDY

1. Why is "cramming" an undesirable way to learn?
2. What are the disadvantages of learning anything bit by bit?

3. Are you acquainted with any mnemonic aids in learning? What observations have you made concerning the uses of such aids?

4. What sort of material do you have to study most slowly?

5. Do your likes and dislikes affect the tempo of your study?

6. Why do you usually know the first part of your lessons better than the last?

7. How does age affect the capacity for learning?

8. What goes on in the nervous cells when the conscious act of studying ceases? Why should we rest for a short time after studying one subject before taking up another?

9. What is learning translated in nervous terms? Mention five things upon which the changes in the synapses during learning depend?

10. Why is it more difficult to learn two languages at the same time than to master one at a time?

11. Report upon exercises 1, 2, and 3, page 296 *Human Behaviour*, Colvin and Bagley.

## References

Colvin and Bagley. *Human Behaviour*. Chapter 17.

## Questions for Re-education

1. Do I dawdle over my books?

2. Have I learned how to go at studying in a practical way? Have I tried to apply the principles I have learned?

3. Am I lazy about looking up words I don't know?
4. Do I study anything outside of my lessons?
5. Have I the ambition to have a mind trained to study?
6. Do I get any real joy out of learning?

# CHAPTER XIII

## THINKING IN IMAGERY

IMAGINATION is the mind's game of "Let's pretend." There are two ways of playing the game—by summoning the past back in mental "movies" and other images (reproductive imagination), or, by creating new things out of the old, putting together remembered things in any combination we may choose (productive imagination). There are those who play the game well in the first fashion, but have no knack at the second. Those who have particular adroitness in creating new forms out of the old, give the world its liveliness. Glorious plans, wonderful inventions, fascinating adventures, are carried out in the imagination before they are worked out in actual experience.

"I'm going to build an aerial bridge," says one of this ingenious throng.

"What? A bridge in the air?" ridicules Stick-in-the-Mud. "No one ever saw such a thing."

"*I* see it, in my mind's eye. I've made it out of old things—part of this—part of that. It will work out—you'll be crossing the river on it one day."

"I'm going to build an airship," says another.

"An airship? Nonsense!" cries Stick-in-the-Mud.

"No nonsense about it—I can do it. It's a patchwork of things people take as a matter of course. There's the swoop of the gull's wing in it for one thing. Watch for my airship in the sky!"

The images of the aerial bridge and the airship proved practical. They stood the tests of making them as truly real as the images were real, in the inventive minds. . . . Every achievement is backed by imagination. The little child, building his house in the sand with "a porch like grandfather's," a roof "something like the church and something like the garage," windows, "the long pointed kind," makes use of his imagination not less than the reconstruction worker, rebuilding devastated villages.

The fact that the mind has this wonderful power to project itself into the future, brings about the so-called progress of the individual and his world, or, his downfall and the consequent splotch upon his environment—according to the particular way in which his productive imagination works in devising new out of the old. "He has imagination," we say of the man who lays before the world a plan for social betterment, or creates an inspiring book, or fashions a fine statue. So too we say "He has imagination," of the man who sends bombs in "novelty"—stamped packages, or plans

a social revolution, or covers crime with picturesque blinds. Whether imagination leads us to attempt worthy or unworthy things, to plan sensible or foolhardy action, depends upon how the past looks to us in imagery and the individual stamp we give to the rearrangement of it. Imagination may be an aid in human adjustment or it may lead to irresponsible, senseless conduct.

Imagination itself is real, whether it will "work out" or not. Experiments that fail may prove "in actual experience that an image is unpractical," but they do not prove that the image is "unreal." Productive imagination may spend itself in creating *fancies*—such as kewpies and woops, that can never be realized in actual experience. Nevertheless, fancies cannot be ignored as something "false," apart from the useful thinking processes. Along with reason and memory, imagination plays its part in higher thinking. The potent force of imagery in forming plans, creating hopes, shaping ideals, cannot be overestimated. The finest patterns of behaviour are created by practical imagery. The word "practical" should not suggest dull routine and grey commonplaces—through aspiration, it may be touched with radiance. Scientific investigators like Priestley, Pasteur, Roentgen, Dakin, and scores of others who have helped the world by their achievements, made use of imagination in a practical way. But for her flaming imagination, Florence Nightingale would never have lived out her

ideas of nursing, long since accepted as aids in nursing practice.

"I don't understand how he could do such a thing." This remark implies lack of imagination. How can we hope to comprehend the motives of other people, to enter into their joys and sorrows, unless, from our study of human nature, we can piece together or imagine, their experience? We can scarcely expect to understand, if our mind cannot play the game of pretending to be in another's place.

"I'd love to help her if I just knew how to go about it,"—this familiar excuse bears likewise the stamp of no imagination. Of all that can be said about finding out how to help people, nothing more practical can be advised than, "Use your imagination."

Imagination may serve to sustain cheerfulness when everything else fails. Fancy, when normal and wholesome, is the mind's delight—like a capricious coquette taking her turn at kaleidoscope the memory bits. Sometimes irrelevant, she is never dull—always capable of diverting the mind from gloom despite the reality of unfortunate circumstances.

Says Richard Jeffries, "I think that those who have an imaginative corner in their hearts are better than those who have not. They have a shrine—to a shrine we bring our aspirations; there they accumulate and secretly influence our lives."

So let our imagination be—a shrine. Let us

keep guard well from the dulness of disuse, the precious power of thinking in images, lest the very light of the mind be lost.

The nurse needs imagination, not for special occasions, but in everything, big and little, pertaining to the care of the sick. When she comes in contact with a patient, the nurse receives a good many hints by way of the dress, speech, manner, facial expression of the patient. By way of these hints she can easily imagine the environment to which her patient has been accustomed. Her methods of approach may be aided greatly by her imagination.

The nurse may go a step further and imagine herself in the patient's place. In this way she grows tremendously in the power of true sympathy. Little duties demand imaginative care just as much as the big crises. "What should *I* think if I were in the patient's place and such an unattractive tray were set before me?" "Should *I* be willing to sleep under these unaired blankets?" "Should *I* consider this instrument clean enough if it were to be used for *my* wound?" Such a habit of self-questioning stimulates the imagination and improves tremendously the nurse's own criterion of good work.

Not only does the nurse understand more exactly the patient's needs, she learns better through imagination how to meet them skilfully. For example, if she forms the image of an attractive tray she can work it out more satisfactorily, and

usually more quickly than if she merely tries this and that effect in haphazard fashion. When she gets ready for a dressing, if she will imagine the surgeon standing at work, she can prepare in accurate detail to meet his needs.

Imagination will help the nurse in sustaining her ideal of the kind of nurse she wants to be. If she has always before her, the image of that particular nurse, she cannot help talking, walking, working, playing, planning according to that image. Let the nurse imagine herself doing the thing she aspires to do and her action will take definite form more easily and naturally. Her vision will carry her through the highest forms of service and help her to seize opportunity for unusual effort. "Making mental movies"—visualizing—comes more readily to some minds than others, but it can be cultivated to advantage.

Unless the nurse uses her imagination in the study of certain principles she will find them uninteresting. All scientific study should stir the imagination. Nursing ethics will seem tiresome and "preachy" unless she tries thinking ethics in imagery. Imagination makes vivid how ethical as well as unethical, social as well as anti-social, standards will work out.

"Oh, if I had only thought!" This is the cry of repentance, of remorse. To think—in images—is to forewarn. "If I do this thing—" the mind projects itself into the future, and the image of the result, unsatisfying, conscience-burdening, revolt-

ing, saves regret from the actual misdeed. Imagination can often make a good guess whether a thing is "worth the candle."

If the nurse will cultivate her fancy, she will insure herself against ennui. A true whimsical fancy is a Sprite o' Light, that enlivens many long hours of watching, an inevitable part of nursing service. She may also lend her fancy, to the delight of patients and companions.

The patient needs to use his imagination particularly in keeping the image of himself in health vividly in mind. The nurse can help the patient by calling to mind this image at trying times. She helps him through wearisome treatments by saying "Think of yourself swinging down the street to your office—isn't it worth enduring these treatments a little while longer, to walk like that again?"

A patient like Pierre La Vaque, who is easily discouraged in learning a new occupation, will need help in imagining himself working well enough to earn a living in the strange way. If the nurse shows Pierre pictures of other crippled men who are earning a living in the same way and follows with remarks about Pierre's own possibilities, she will make his imagery concerning the future much clearer. He will have more confidence in the practical working out of the new.

"Imagine yourself, Pierre, in the place of one of these men in the picture, taking in money for your work," suggests the nurse. "Soon you will be

taking your money to the bank. You will have a bank-book of your own. Your little nest-egg will grow bigger and bigger. And oh—the good times you will have with your work!"

Thus Pierre forms the habit of making mental movies of himself at work at his new occupation and his interest grows amazingly.

The nurse will avoid provoking imagery that might lead to something the patient should *not* do. Sometimes, in her anxiety to keep the patient from doing anything harmful during her absence, the nurse warns him not to do this, not to do that—mentioning things he would never think of doing had his mind not been set going inadvertently by the images thus suggested.

The patient needs to be forewarned at times, but the nurse should take the precaution, not to overdo such suggestion.

Through the ravages of disease, patients often lose the power to visualize. They cannot bring to mind pictures of things in the past, nor can they do even the simplest productive imagining at times.

"I have forgotten so much," sighed a patient, lying long ill with typhoid fever in a foreign land. "I can't call to mind the places at home; even the faces of my friends are a blur." But he had not forgotten. His power of thinking in images was gradually restored. It was as if his mind had to be bathed in the chemical of health to "bring out" the faded impressions. His was not an unusual case. Visual, auditory, motor imagery seem par-

ticularly affected by disease, although patients may lose any type of imagery temporarily. Shell shock furnished many interesting examples of imagery lost and restored. . . . The nurse, knowing that "forgetting" of this kind may be only a temporary state, may encourage the patient by a simple explanation. Patients become melancholy, even panic-stricken—over the loss of imagery, thinking it will be permanent.

Patients often have unusual imaginative experiences—fantastic and horrible rearrangements of old experiences take place in their minds. Some drugs tend to make the imagination more active. Such images are not images of health. They may have a strong influence upon the patient, temporarily depressing or disturbing him. Imaginings of this kind are not to be confused with hallucination and illusion, although it sometimes happens that wild flights of the imagination are preliminary to false perceptions. Divert the patient from images of any character that have a tendency to upset him.

## Definitions

"*Imagination.*—What it is.—*Sensations*, once experienced, modify the nervous organism, so that copies of them rise again in the mind after the original outward stimulus is gone. No mental copy, however, can arise in the mind, of any kind of sensation which has never been directly excited from without. . . . Fantasy, or Imagination, are the names given to the faculty of reproducing copies of originals once felt.

The imagination is called 'reproductive' when the copies are literal; 'productive' when elements from different originals are recombined so as to make new wholes." (William James, *Psychology*, p. 302.)

### Questions for Study

1. How does productive imagination differ from reproductive? Give examples of each kind of imagination from your nursing experience.

2. Before Bessie McCaskell entered the training school, she imagined from romantic story-reading, the life of a nurse to be very different from what she finds it to be. Suggest ways in which this imagery might affect her behaviour at first. What is the probable reaction when she finds her image of a nurse one that will not fit into the training school?

3. When you have a concrete image in mind, are you always able to summon the symbolic?

4. Think of biting into a lemon, or eating a mouthful of green gooseberries. Is your gustatory image equally well-defined in thinking of eating a piece of lettuce? What makes us able to form gustatory images of some things more definitely than others?

5. A patient asks the nurse to hand him "that thing out on the hall table," meaning his letter-case. What imagery is lacking? Do you often encounter lack of this type of imagery? Give examples from your nursing experience.

6. Give illustrations of imagination that has led to great achievement; to unworthy achievement; to impractical experiments and failure.

7. Can you give some examples of poetical fancy that you enjoy?

8. What are your ideas upon the subject of "telling children there is a Santa Claus"?

9. Have you ever known a child to "get mixed up" in his game of pretending—to confuse the real with the fancied?

10. Why does a nurse need to use her imagination? Have you noted situations that would have worked out better if the nurse had used her imagination?

11. What points should the nurse remember in regard to the patient's imagination?

12. Give some illustrations of lost power of imagery in illness.

13. Give in exact words a picture of the kind of house you would like to build.

14. Plan an ideal sick-room. Include the color of all details.

15. What is the advantage of the nurse's mind "running on before" in her work?

16. Do you think the habit of seeing motion pictures helps or hinders the power of visualization?

17. Make up a movie story for your own amusement. Let your imagination project each scene and action upon the screen.

18. Without referring to the personality sketches of our five nurses, write out a description of each girl as you see her now in your mind. Compare your description with the personality sketch. How much of it is filled in by your imagination?

## References

Colvin and Bagley. *Human Behaviour.* Chapter 14.

JAMES, WILLIAM. *Psychology, Briefer Course.* Chapter 19.

### QUESTIONS FOR RE-EDUCATION

1. Do I try to illustrate principles of ethics in my mind by visualizing the action which results from the application of these principles?

2. Do I take pleasure in fancy?

3. Have I the power to imagine myself in another's place? Do I try to do this in getting in touch with people? When people tell me their troubles, does my mind actively work to imagine such situations as they describe, or, does it remain passively unsympathetic?

4. Have I ever tried to imagine myself doing something unusual in the way of service?

5. Is my power of productive imagination weak? How may I measure its power?

6. Do I allow my imagination a place as important as reasoning in my thinking processes?

7. Do I have a clear image of the kind of nurse I should like to be? What part does my professional ideal play in defining the kind of woman I wish to be?

## CHAPTER XIV

### REASONING

When we think with a purpose, we call it reasoning. "Turning an idea over in the mind," means subjecting ideas to reason. This we must do when we encounter the new, if we meet it as intelligent human beings. Reason is the guide to the uncharted. Although we do not *know* our guide is right, we *believe* in the safety, the common-sense of reason. "It stands to reason," we say and go ahead with confidence.

The expression, "Let me think," means, in other words, "Let me reason—let me fix my attention upon the thing in hand; let me get my idea council together to talk it over and reach a conclusion."

Real thinking is not a simple process. It means *work* for the mind.

We say that we learn by experience, meaning, that we find out the flaws in our reasoning processes. Our judgment develops according to our skill in sorting out concepts. "This belongs here—and this, there—says the keeper of the mind systematically identifying and relating ideas, making one judgment after another, until a decision is

reached. The power of sane judgment is the basis of all sound reasoning. The mind that can cluster together without confusion, the ideas necessary to construct a particular decision—and only those ideas—such a mind has the ability to think—and to think clearly.

The fact that many people do not solve their problems by the rational method, keeps the world continually upset. Doing things because we "feel like it," regardless of principle or consequence, indicates a lack of trained reasoning.

How may we learn to reason?

1. By using our eyes, first of all, to observe minutely, accurately, fairly.

2. By forming the habit of comparing things with precision; noting fine differences and likenesses; seeing what really exists uncoloured by prejudice.

3. By adopting "Wayte awhyle—wayte awhyle" as a motto; conclusions of value require certain deliberation.

4. By *order* of the idea-cluster.

5. By applying principles to specific circumstances; by developing appreciation of correct standards.

The nurse must use her reasoning powers constantly.

First of all, in applying psychological principles, she needs to exercise keen judgment. Without it, whatever knowledge she may have of psychology will not work out in a practical way.

Very often the physician says to the nurse, "Use your judgment," and the nurse is expected to use her thinking powers wisely for the welfare of the patient. She is to administer medicine under certain conditions—she must be able to identify those conditions. She is told to give the sedative "if the patient needs it." If she administers it without first taking every other means to quiet the patient she shows lack of judgment. The nurse must get her "cues" from accurate observation of the patient.

Although the nurse is said not to act upon her own initiative, we know that situations constantly arise, when the physician says, "Leave it to the nurse." More and more physicians depend upon the intelligent reasoning of the nurse in carrying out complicated treatments. Crises occur when there is no time to consult the physician—the patient's life may depend upon the quick action of the nurse. She is expected to rise to every emergency. How can she do so without reasoning? To be sure, the nurse is expected to "follow the doctor's orders," but seldom can she do so, without using her judgment to supplement that of the physician. There should be no contention concerning the "place" of the nurse. Her own duties are sufficient without taking on those of the physician in addition. However, in pursuing her part of caring for the sick, she is far from occupying the place of a marionette. The nurse and the physician are inter-dependent. The nurse who is

most competent is the one who knows how to think. All fields of nursing service, demand that a nurse should "use her head." Hospital and institutional nursing—including executive positions and technical specialties, such as operating-room work, administration of anæsthetics, massage, hydrotherapy, electro-therapy, laboratory work, educational work, visiting nursing, infant welfare work, school nursing, medical social service; industrial nursing, Red Cross nursing, private and office nursing—can we think of any kind of nursing that does not require trained reasoning power? It can be said fairly of any one assuming that the profession allows no expression of the initiative, "He does not understand the duties of the nurse."

As a rule, the patient's imagination will do more for him than his reason. As previously stated, we must not expect too much reasoning on the part of the patient. He merely "feels." His conduct is largely instinctive. He is too weak to reason. In fact, he is often incapable of it, even when he is said to be "in his right mind." The nurse is unwise to force the reasoning process upon her patient. *Never argue with a patient* is a safe rule to follow. The effort to argue a patient out of an idea, nine times out of ten, results disastrously. *Appeal to his imagination, rather than his reason,* if the problem gets beyond instinctive responses. As the patient convalesces, as his power of attention returns, he may gradually resume the task of reasoning. Because reasoning is such very

hard and exhausting work for the patient, he should be spared the process as long as possible. The nurse must often do the patient's reasoning step by step for him.

## Definitions

"*Purposive thinking.*—Purposive thinking equals spontaneous thinking plus selection. We distinguish spontaneous or aimless thinking from controlled or purposive thinking. In the former ideas flow on at random, unchecked by any interference on the part of our general intentions and aiming at no desired goal. The prattle of babies, the reveries and haphazard trains of thought which come as we sit idly thinking of nothing in particular, and the majority of dreams are of this sort. In the latter some end is in view; our thoughts are kept so far as may be under control and make an intelligible sequence. . . . In spontaneous thinking we take whatever comes. In controlled thinking we select and reject in view of the goal we wish to attain." (E. L. Thorndike, *Elements of Psychology*, p. 264.)

"*Inferences.*—When one thought or judgment calls up another leading on to some related conclusion the process is called an *Inference*. . . . A series of such directed thoughts or inferences is called *Reasoning* or *Rational Thinking*." (E. L. Thorndike, *Elements of Psychology*, p. 17.)

## Questions for Study

1. Give an illustration of reasoning as distinguished from judgment.

2. Should you use inductive or deductive reasoning in convincing Pierre La Vaque that he can earn his living by his new occupation? Outline the steps of your reasoning.

3. How does the process of thought differ from emotion?

4. Contrast the rational attitude with the emotional attitude.

5. What is the distinction between "tentative hypothesis" and "laws"?

## References

Colvin and Bagley, *Human Behaviour*, Chapter 18.

Pillsbury, W. B., *Essentials of Psychology*, Chapter 9.

## Questions for Re-education

1. Do I know how to reason?

2. Do I use my reason in a practical way? Am I inclined to do things because I "feel like it," without thinking of consequences?

4. Does my judgment prove good in my nursing practice?

5. Have I a trained reasoning power?

## CHAPTER XV

### Feeling

Along with our sensations we have *feelings*. Feelings may be simple—either pleasant or unpleasant, or, they may be intensified and complex to the extent that they are called *emotions*.

We say of one person that he is "indifferent"—that "nothing matters to him." Of another, we say that he "takes things too seriously"—that he "wears himself out by his emotions." Here we have the two extremes of affection, as psychologists term all states of feeling accompanying consciousness. The individual who "feels" life in general, has a warm personality, sure to be of interest. The cold being, who appears unaffected by everything, has nothing of companionship about him. Conventionality leads us to cover up our feelings more or less—often to the extent of making us appear what we are not. We go along politely avoiding any "outbursts," lest we offend. Time was, when it was considered "the thing" in society to appear utterly bored with everything. Nowadays, we must seem pleasantly entertained, no matter how bored we may be. We practise

restraint as a matter of course. We remain outwardly tranquil no matter how we feel. We seem ashamed of emotion, even if it is good emotion. Control of undesirable feelings is commendable—no one caring for the welfare of the individual or of society, could advocate throwing off such restraint, but the check of natural wholesome, lively feelings, the covering up of real personality—this deplorable tendency robs society of half its interest. While it is well to avoid "bad" emotional storms, not only for our own sakes, but of those around us, we may exercise emotions of a character, undeniably good, if not carried to excess. Sympathy, for example, need not become maudlin. Although we should "give primary attention to what we *do* and *express* and not to care too much for what we feel," as James suggests, let us not try to get along without it altogether. Without it our actions, our varied expressions, lose all colour. We become monotones of consciousness—altogether grey. Without feeling, we are neither one thing nor another.

Whether emotions are considered as intensified feelings, or native feelings with a strong instinctive basis, or bodily sensations we know them as powerful influences in our behaviour.

The nurse, above all other women, needs feeling. The finer her feelings, the better service she can render. As a background to her professional life, she needs a well-developed feeling for art. An emotional thrill from a good play, a painting, a

piece of sculpture, will do her a great deal of good. she should have something more than a merely intellectual appreciation of the best there is in art and nature as well. Nurses who have such feeling get the most out of their precious hours of recreation. They come back on duty feeling that they have been very far away from the sick-room. It is deadly for the nurse to let the life outside her professional circle go on unnoticed, unappreciated.

While in general the nurse's feelings may ebb and flow, she should never alter in her "feeling" for her patient. The true nurse feels the needs of her patient—she *cares*—not spasmodically, but continuously and deeply. The nurse who does not have this "feeling" for her patient is better out of the profession. The patient senses at once the absence of such a feeling. If the nurse has it—no spoken word is necessary. The patient *knows*.

"Don't let her inside the room again," begged a patient as his nurse, accounted "perfect in technic," closed the door to go off duty. "She may know how to do things but she is like wood."

This patient did not want any demonstration of "feeling." He only wanted "someone around that cared." Such feeling has nothing to do with emotion, which, in any form has no part in the nurse's work.

The nurse is always careful not to show in the sick-room any emotion over her personal affairs. She should be able to go about her duties with a

semblance of cheerfulness, although she is suffering from sorrow. She should never excite the patient's pity by talking about her own griefs. Too much exuberance over personal happiness is also out of place in the sick-room. The nurse's personal emotions must be kept in the background so long as they do not in any way concern the patient.

Occasionally the nurse will come in contact with patients that stir in her undesirable emotions, such as disgust or fright. She can overcome revulsion in caring for the most loathsome diseases by assuming the same attitude toward a so-called "nice" patient. She must not allow herself to take on the bodily posture indicating repugnance. If she will make every effort to act toward all patients with the same manner, she will find herself making no distinction. She shows the same solicitude toward all. She distributes her smiles impartially. If, in dealing with a delirious patient, she allows herself to shrink, she will only increase her own fright, as well as lose control of the patient, who is easily affected by signs of this emotion. If she will advance, with calm and easy manner, speaking in her natural voice, she will find herself soon in control of herself. As soon as she masters herself, she is on the way to master the patient. . . . Giving way to laughter at inopportune moments may be averted by deep breathing or by getting the mind upon something else. The nurse should never allow herself to go on duty, showing by her walk, her facial expression,

her voice, that she is disturbed by an undesirable feeling. Let her walk as if she has a feeling of well-being, look as if her mind is serene, speak as if she is happy—and such a course will help in a measure to bring about the desirable change. When she is tired and disgusted with study, if she holds her books as if she respects them, sits in an attitude that indicates interest, she will be able to master herself to a great extent.

The nurse has ample opportunity to observe the effects of feelings and emotions. She notes that the organism is electrified by pleasant feelings and depressed by unpleasant. Likewise, the organism in sickness, causes unpleasant feelings about things in general, just as the organism in health induces a pleasant outlook. The nurse remembers in dealing with everyone that the way a person feels physically has a great deal to do with the way he "takes" things, therefore the bright eyes, the good colour, the buoyant carriage of good health, the dull drooping lids, the telltale skin, the dragging step of low vitality, take on a special significance to her.

"My headache is all gone now," announces the patient, after receiving some good news that dispels anxiety—the cause of his headache; or, if his disease is deep-seated enough, he may disappoint his friends by his seeming indifference concerning some good word, their gifts, or even their presence. When he begins to get the upper hand of disease, his attitude becomes more normal. He has al-

together a different feeling for the roses that are brought to his bedside, for the bits of cheer from the world outside his door. The nurse realizes that she cannot nurse the patient's body and take no account of the way his illness colours his outlook—nor can she disregard the effect of his feelings upon his health.

In dealing with emotion, the nurse will be helped by making use of the following facts:

1. In emotion there is *suspense*, from which results strain. This strain is followed by a bodily reaction, particularly in connection with undesirable emotions. Sometimes, after an emotional upheaval, there is extreme weakness, even collapse; a pounding headache, or bad heart action from the disturbed circulation; nausea and indigestion. The senses may fail to act normally for a time after an emotional outburst. After giving vent to strong emotion, an individual "pulls himself together" with difficulty. Such reactions are bad for people in health—they may result disastrously for the patient. It must not be forgotten that an emotion, such as joy or sympathy, that may cause no ill after effects in health, frequently harms the patient. Knowing that all emotion is undesirable as a rule for the patient, the nurse tries to manage things so that his feelings do not become intensified unduly. The run of the patient's feelings should be uninterrupted by any sudden upheavals. He should "go softly." Surprises, well enough meant, often affect the patient unpleasantly. Anger and

terror are particularly injurious to the sick. The heart and lungs, so strongly affected by these emotions, often fail to bear the added strain, and death ensues. Patients afflicted with diseases of the heart and brain undergo emotion at the risk of their lives.

Only when the case presents a very unusual situation should emotion be excited deliberately.

If the patient can be brought to a desired attitude only by means of emotion—everything else having failed—such a course may be considered. The means is undesirable, but, under the physician's direction, it may be taken in view of the end to be secured. Circumstances arise when the patient must "learn his lesson." Sometimes as in the case of patients afflicted with drug habits, the mind must go through the shock of emotion, before it is possible to make a new adjustment. It is well known, however, that nothing permanent can be expected from remorse and accompanying resolve, unless a sustained feeling—or mood—is carefully fostered. It is impossible as well as undesirable to keep the patient in a long-continued state of emotion. It is only what is left over from the emotion that will serve any helpful purpose. This is the moment to fix the attention upon something new—that which means the very life, perhaps, of the patient.

2. Behaviour under emotion is uncontrolled. People under the stress of emotion seem not to know what they are doing. On the part of the

patient the nurse may guard against sudden and purposeless movement. When encountering emotion on the part of the patient's family, the nurse will avoid, if possible, relying upon them for important duties. Giving them something to do to steady them is desirable, as this gives them the feeling that they are of some use and their emotion is discharged in this way—but not too much dependence should be placed upon any one in the midst of extreme emotion. Such a one must be "brought to himself" by the realization that his help is needed, before he is in any bodily or mental state to be of real service. His confusion of thought, together with his uncertain execution, will vanish with his emotion, as he devotes himself to a definite act.

The nurse needs to be skilled in controlling emotion. It is not enough for her to recognize emotion and its cause. She must know how to deal with it.

First of all, she will try to avoid emotional upheavals in her patient by keeping away from him things that will excite emotion. She tries to build up desirable feelings—a lasting mood—that will keep her patient in a quiet, contented frame of mind.

If emotional outbursts occur, as of course may be expected with certain types of patients and with almost any patient under particular circumstances, the nurse will immediately get the patient out of the bodily attitude that characterizes the emotion. This is perhaps the wisest "first

aid" to render. If the patient buries his face despairingly in his pillows, let the nurse lift him gently, rearrange his bed so that he is in the attitude of a contented, comfortable patient. He may wish to be "let alone"—but the nurse will easily find a reason for such readjustment of position. Giving a drink of water is a simple aid in helping the patient to gain control of quivering lips and shaking body. If the body *has* to attend to something else it will give up the movements that express the emotion. This suggestion can be carried out in a variety of ways, according to a patient's condition and the particular emotion expressing itself. The change of position should always be brought about easily, without struggle on the part of the patient. Often he can be induced to make the change himself at the suggestion of the nurse. So long as he does not guess the reason for it, and there is no resistance upon his part, such a means of working out an emotion cannot fail to help. Patients often "go off on a tangent" over very little things, and they may be just as susceptible to management which seems exceedingly simple.

A higher feeling or emotion may control a lower one. It is difficult to quiet the patient unless his feelings are directed definitely in some other direction. The nurse must use her ingenuity in bringing to bear different feelings on the part of the patient. If action can be combined with such an effort so much the better.

In dealing with anxiety, the nurse will keep the patient occupied whenever possible. Waiting seems interminable to the patient if he is overwrought concerning an operation. He is not always able to do things with his hands, but if he can do so, it is a safety-valve. If left to himself, he may not be able to get down to doing the particular thing in hand—the nurse will find it necessary to take an interest and perhaps a part in the diversion. If he must remain perfectly quiet, the nurse may see that his mind is not wholly occupied with the coming operation.

The nurse often finds the patient's family "under the weather" particularly at the beginning of the patient's illness. Their vitality is lowered by fear and oppression. She will always help them by building up their confidence, if possible, in the help that is rendered the patient. If they cannot be of service themselves, the next best thing to them is knowing that someone else is doing, adequately, the thing that needs to be done. Much anxious waiting, so conducive to emotional storms, may be obviated by sending them on errands, or enlisting their help as much as possible. If they are "kept going" they have no time to throw themselves in a chair and give way to despair. It is much easier to ward off upheavals than to deal with them.

The nurse may learn through the study of temperaments, the emotional tendencies of the differ-

ent types. While she cannot pigeon-hole people by labelling them hard and fast as sanguine, choleric, melancholic, or phlegmatic, an understanding of these four types will help her greatly in her speculations of "what to expect." A patient who is phlegmatic shows the least emotion. His movements are always deliberate and slow, in health, and in sickness the same tendency is noticeable. While the nurse will usually have fewer upheavals to deal with in this type of patient, she will find him harder to dispossess of ideas, more "set," once he makes up his mind to a thing. The strength of his will is sometimes amazing. In emergencies, such patients show less excitement, and complicate things very little by unexpected movements and outcries. The sanguine type is the most hopeful of all. He is not hard to please, and will complain less than other patients. If anything goes wrong, he is quick to let it pass. In his excitement—which is often evident over little things—he is diverted with comparatively little difficulty. He will often do erratic things under stress of emotion, particularly in connection with his movements. If delirious, he needs the closest watching. In convalescence he likes to be doing something and finds pleasure in very simple things—often appearing almost childlike in his attitude toward entertainment. He may seem to feel very much out of sorts and in a short time be all smiles again. This type may show many foibles and weaknesses,

not always easy to tolerate. The choleric and melancholic types are the most difficult to deal with in a general way. The choleric has more complaints to make than any one else—things are always going wrong according to his point of view. He is easily "put out." Usually he doesn't like his nurse. He is not satisfied with his treatment. He shows anger very often over trifles. He is very much affected physically by his outbursts. He may know they are "bad" for him, but he persists in letting himself go at the slightest provocation. With this type the nurse will have to bend every effort to build up a strong feeling of well-being as a safe-guard against emotional storms. He must receive the impression constantly that "everything is going all right." Little jars must be kept from him. What would appear to other patients as matters of no consequence, seem gigantic things to him. He shows the combative instinct when thrown with other patients—he is disposed to argument and likes to stir up trouble. When delirious he is usually obstreperous in the extreme. Like the sanguine type, he is quick in action—but he is much stronger. His ideas of what he wants to do are usually sharply defined. Sometimes he has horrible hallucinations against which he puts up a terrific struggle. Someone is trying to do him harm—this is the trend of his delirious raving. The melancholy type is chronically low-spirited. He is very hard to "cheer up." He seems to prefer his woes to anything

else. In working to get his attention upon things of pleasanter nature, the nurse will often feel that the psychological moment to strike will never come. She has to manœuvre in all sorts of ways to get a glimmer of interest from him along the line she desires. He will often nurse his grievances, or supposed grievances, in silence. If he is displeased with anything, it is sometimes hard to get him to tell what it is. His brooding is often painful to those about him, but he is too much absorbed in himself to care how other people are affected by anything he may do or say. A certain sentimentality underlies his train of thought—the particular turn of this sentimentality may be hard to understand. He is emotional—but not in the chaotic manner of the choleric type. He is weaker, not only in the power of emotion, but in his ability to master himself, once he is "set going." His movements are rather slow—he doesn't like to be hurried. If he likes a nurse, no other will satisfy him. There are so many mixtures of types that such a sketch can be used only as a general sort of guide.

## Quotations

"*Emotions Compared with Instincts.*—An emotion is a tendency to feel, and an instinct is a tendency to act, characteristically, when in presence of a certain object in the environment." (William James, *Psychology*, p. 371.)

## Questions for Study

1. What is emotion?
2. Compare mood and emotion.
3. What is the James-Lange theory of emotion?
4. How may a nurse help herself in mastering repugnance in caring for a loathsome type of patient?
5. Give examples drawn from your nursing experience of the effect of emotion upon the body; of the effect of illness upon the feelings of the patient toward things in general as contrasted with his attitude in health.
6. What points should a nurse observe in attending a patient acting under the stress of emotion?
7. Why is emotion usually bad for the patient?
8. Describe the four traditional temperaments as they express themselves in sickness.
9. What is the temperament of Mrs. O'Brien? Pierre La Vaque? E. J. Andrews? Which patient is easiest to manage?
10. Have you observed any good results from arousing emotion in patients?
11. Why is feeling aroused by imagined situations of particular value in dealing with patients?
12. Mention instances when nurses have failed to show respect for the patient's feelings.
13. Nurses are sometimes criticized for not respecting the feeling of modesty in their patients. Can you suggest the reason for such carelessness? How may it be prevented?

Colvin and Bagley, *Human Behaviour*, Chapters 5 and 6.

Pillsbury, W. B., *Essentials of Psychology*, Chapters 11 and 12.

James, William, *Talks on Psychology*, "The Gospel of Relaxation," p. 199.

James, William, *Psychology, Briefer Course.* Chapter 24.

## Questions for Re-education

1. Have I well-defined likes and dislikes? Do I speak oftener of the things I like or the things I dislike? In recounting an experience, do pleasant or unpleasant details predominate?

2. Do I try to have something pleasant to say when I meet people? Have I a tendency to pass on my unpleasant feelings? When I do not "feel like talking" do I allow myself to forget my social obligation of doing my part in sustaining conversation?

3. Is the general tone of my letters pleasant or unpleasant? Do I allow myself to write under stress of undesirable emotion?

4. What is my temperament? In studying the four traditional temperaments, do I admit my own tendencies frankly?

5. What intellectual "feeling" have I for art? Am I touched by fine appeals of all art? Have I anything more than an intellectual appreciation of the beautiful?

6. What sort of things arouse my emotions? What significance do I see in my answer?

7. Can I control my emotions properly?

8. When have I had reason to be ashamed of an emotion?

9. When has my ignorance concerning something

artistic, caused me to feel indifferent to something highly desirable?

10. Am I inclined to cry over a sentimental story or play and remain untouched by human life? What does such a tendency indicate?

11. Do I recognize the difference in the likes and dislikes of various temperaments? Do I expect the same "feeling" concerning a particular play, a colour, another person, and so on, from all my friends? Have I a tolerance for other people's prejudices? Do I label as "queer" any feeling that is not like my own? If there are some things about a person I do not like, am I unable to meet him on other common grounds of interest? Have I the faculty of enjoying what I can in people, and not making too much of the things that jar upon me?

12. Am I tactful in not arousing antagonism by expressing my feelings too radically to someone who feels just the opposite? When has such expression on my part led to strained relationships? If I do not agree with people, is there any reason why I should be less courteous to them than to others?

13. As a nurse, am I discreet in keeping my feelings to myself at times when the expression of them would be unprofessional or upsetting to someone else?

14. Have I the true nurse's "feeling" for my patients?

## CHAPTER XVI

### WILLING AND DOING

How are actions controlled? How is the decision, "I am going to do it," put into execution?

In the consideration of attention, control of ideas, the answer has already been signified.

Bessie McCaskell wishes to go to the movies, while Mary Anderson wants to go for a tramp in the fields. Hereditary tendencies as well as previous experience and the mood of the moment, enter into the difference of their desires and consequent action. Our ancestors are at our elbows, nudging us to seek this and that action. They have a great deal to do, also, with the tenacity of our purposes. Whether heredity has more to do with our action than environment and training is a question much discussed. Suffice it to say, both heredity and training enter into our decisions in varying degrees. So much depends upon the susceptibility of the individual to the "lessons" of teaching and experience.

Psychologists speak of two kinds of action: action due to interest; action due to duty—the former giving immediate pleasure, the latter,

future. Duty as distinguished from desires in this connection arise from social influences and ideals. To desire one gives involuntary attention; to duty, voluntary. However, the execution of duty need not imply lack of interest, although it is of a different type than that given to the gratification of desire.

Duty is constantly entering into the problem of choice. "I'd like to go to the play," says Ann Sherman, "but I must stay home and put in some extra time on my Materia Medica—I'm 'way behind you know," Or, "I couldn't enjoy the music, because, in order to hear it, I broke a promise to spend the afternoon with my deaf aunt," confesses Frances Tracy. Thus, duty may interfere with possible pleasure. Our conduct strikes a fine balance, indeed, if we may pursue our desires without being troubled by "the voice of duty."

The nurse is directly concerned in her work with distinguishing between the two recognized types of will, called by James, the *precipitate* and the *obstructed* will, respectively.

When she says of her patient, "I never know what he is going to do or say next," she recognizes the precipitate type. Such a patient shows little or no control. Without deliberating, without giving time for inhibition—away he goes. He is "off on a tangent" most of the time. Individuals, ordinarily not showing the precipitate type of will, may show a tendency to it, particularly at the onset of disease. Sickness shows itself in the

discharge of action wholly unlike the patient's usual course. "He isn't himself, or he wouldn't do things like that," comment the friends of the man who is on the verge of sickness. A character normally controlled by inhibitions, is broken down by disease. In many ways a man is more himself—his natural self—in sickness than in health. His friends know the conventional, restrained man, his nurse, the natural man.

When the nurse sums up another patient by observing, "He is like a man hypnotized—he is afraid to do anything," she recognizes the obstructed type. Such patients cannot will. Because they think they are helpless they *are* helpless. Possessed by fear, they are impassive. The will seems for a time overcome. It can no longer get the better of resistances; its energy is taken away. In extreme cases, the will is so obstructed that the patient cannot be induced to try doing the very things that will "do him good."

In dealing with the precipitate type of will, the nurse will often have to prevent the discharge of the patient's ideas into action. The patient must be kept from doing things that will injure him. How is she to prevent such expressions of the patient's will? She has learned much already through her study of instinct, sensation, and attention as applied to the patient. To be emphasized at this point is the fact that the desired inhibitions may be brought about by suggestion. The nurse must use her judgment concerning the

particular kind of suggestions to be used. The patient is scarcely likely to "settle down" of his own accord. Diversion by action other than the patient at the moment desires, must be undertaken carefully. He must never suspect that the suggested action is in opposition to that he himself proposes to execute. If he can be "put off," he will enter into something else willingly and thus the undesirable action, for the time at least prevented. Constant ingenuity on the part of the nurse will be required to avert the carrying out of all sorts of sudden "notions" so characteristic of the precipitate type. Above all, the nurse must recall that all-important principle, "Human resistance is universal."

In dealing with the obstructed type of will, the nurse has need of great tact and patience. It is of no use trying to make the patient do things by saying that he must do them. The nurse may be sorely tried in meeting the conditions of over-inhibition, but she must not lose faith in the cumulative effect of suggestion. Little by little, the change may be brought about. Failure to make the patient inclined to the desired action, may be due to the fact that the nurse does not grasp the psychological moment when he is susceptible to a new interest. To secure the active interest of such patients may take months. Patients who do not exert their will to get well must be made to care again for life. "The world needs me!" If the patient once gets this idea, he is likely to be

stirred to a change of attitude. . . . Occasionally, as in cases where a patient can't walk or use his hands merely because he will not make the effort, some suggestion amounting to a shock may be required to stimulate him to action. Instances are on record that patients, inhibited by the idea of helplessness, have been brought to their feet in the face of danger. When life, either of the patient, or of a loved one, depended upon movement, action came. When premeditated, such crises must be carefully calculated. Such experiments are never undertaken except under the direction of the specialist in charge.

If a patient is "balky," the patient cannot be treated as the obstreperous child is sometimes unwisely managed. The nurse must never pit her will directly against that of the patient. She might win, as the stronger of the two, but the best interests of the patient would be sacrificed. Let us suppose a patient a-quiver over having to go through with something at which he has failed in his initial effort. "It's no use," he insists, "I can't do it—I'm not going to try it again." It may be some treatment which depends upon his co-operation—some course of action vital to his interests. Even so, it is just as well at the moment not to remind him of this. Later on, he may be brought to the realization, but at the moment of rebellion, he is in no mood to hear *why* the thing should be done. If time will allow, the nurse does not press the subject. She makes use of

one of her "handy" remarks, previously suggested: "We'll see what can be done," "No need to think about it now—it will work out all right," or, "We'll do what is best." The main thing is to dismiss the thing casually and to follow with a decided diversion. Make it a point to get the patient's mind just as far away as possible from the subject that is upsetting him. Here the nurse's cleverness will tell. Is she wise enough to get at the patient's will in a round-about fashion? Does she know how to make him say, finally, words of submission, that she has "put into his mouth" though he doesn't guess it? Is she able to present the momentous decision in a new guise so that the patient will accept it? Of the two types of inhibition, *i.e.*, by repression, and, by substitution, as designated by James, the nurse will understand why the latter is the one to be used with the patient. The strain and the tension of inhibition by repression, so trying even to the individual in health, is exhausting to the patient. Moreover, the results are never satisfactory.

The nurse soon learns that the Latin character shows the precipitate will more often than the English; that the uneducated, oftener than the educated, give examples of uncontrolled action; that the weaker the patient from disease, ordinarily, the weaker his will.

The red-tape of willing-to-do sometimes encountered by the nurse in public-health or social service work, proves exasperating. Scruples! Checks!

Constant repression! Prudence! Over-deliberation! These are the things that stand in the way of humanity's needs. Curiously enough, they are often encountered in officials who seem to be trying most earnestly to "do their duty." The nurse may try the "shock" method to hurry things along—and, in the meantime, never, never, lose time by losing her temper.

Just as teachers must build up character in their pupils, the nurse needs sometimes to do likewise with her patients, in order to bring about the healing of the body. The nurse finds that she must foster the power of wise choice in her patient. Wills must be nourished as well as bodies. Patients follow the usual course of action when they choose what they are in the habit of choosing. They cannot be made to choose differently unless they "see a reason" or develop higher ideals. It is difficult even when the ideal is established to induce the patient to do what he knows he ought to do.

Developing of ideals is one of the first things to do in public-health work. All preventive work is more successful if undertaken in this way. As demonstrated in such work, play, recreation, living conditions that develop respect for the clean power of the human body, will do more than restrictions to change a community.

If the patient does something he knows he should not do—and patients like other human beings are prone to do this—he should be made to understand the bad results of his action. Unfor-

tunately, the patient cannot be "left to take the natural consequences"—if he were so treated he might not survive to show the effects of such training, but he can be made to *imagine* the consequences. The patient is easily frightened as a rule and a little "scare" over what might have been, may do wonders toward making him somewhat wiser in his choice of action. Patients trying to cure themselves of a drug habit are constantly letting go of the rigid control they know perfectly well to be essential. Such patients may sometimes be brought back to proper state of resolution by a review of their former deplorable condition and a picture of what might be if they persistently disregard orders.

### Definitions and Quotations

". . . The word *will* can be used in a broader and a narrower sense. In the broader sense, it designates our entire capacity for impulsive and active life, including our instinctive reactions and those forms of behaviour that have become secondarily automatic and semi-unconscious through repetition. In the narrower sense, acts of will are such acts only as cannot be inattentively performed. A distinct idea of what they are, and a deliberate *fiat* on the mind's part, must precede the execution.

"Such acts are often characterized by hesitation, and accompanied by a feeling, altogether peculiar, of resolve, a feeling that may or may not carry with it a further feeling of effort. . . .

"If, then, you are asked, 'In what does a moral

act consist when reduced to its simplest and most elementary form?' you can make only one reply. You can say that it consists in the effort of attention by which we hold fast to an idea which but for that effort of attention would be driven out of the mind by the other psychological tendencies that are there. *To think*, in short, is the secret of the will, just as it is the secret of memory." (WILLIAM JAMES, *Talks on Psychology*, Chapter 15.)

## QUESTIONS FOR STUDY

1. Define *will* in words of your own selection, which adequately express all that will signifies, in the broader and in the narrower sense.
2. What is choice?
3. What are the two extreme types of will? What is the difference in the nurse's attitude toward these two types of will, respectively?
4. Give an example of a "balky will" as exhibited by a patient. How was he "managed?" Were psychological principles considered as they should have been?
5. Which type of inhibition is followed with the more desirable results?
6. What points are to be considered in training the will?
7. What course should be taken if a patient does something he knows he should not do? Why may the nurse not treat him in such an instance as she would a person in health?
8. Give some illustrations of the development of ideals drawn from nursing history; from public-health work under your own observation.

9. What is the significance of the terms, a "strong" and a "weak" will?

10. Tell just how you would undertake to develop the ideal of cleanliness in a ward patient?

11. What is the secret of the will?

12. The patient does not use his sputum-cup with care. What are you going to say to him?

13. How would you go about inducing young girls and boys to stand and sit and walk properly?

### References

James, William, *Talks on Psychology*, Chapter 15.

Pillsbury, W. B., *Essentials of Psychology*, Chapter 13.

### Questions for Re-education

1. Do my desires often conflict with my duty? Am I able to make a choice of action usually that is approved both by desire and duty?

2. Is my will inclined to be precipitate?

3. Have I devoted any attention to the training of my will?

4. Is there too much red-tape attached to my choice of action?

5. If, after careful deliberation, I make a choice of action, do I allow myself to wonder whether I have chosen wisely? If the action proves undesirable, do I spend undue time in regretting it?

6. Have I naturally much tenacity of purpose? In what sort of experiments do I give up most quickly? Do I acknowledge failure too easily?

# CHAPTER XVII

## NURSING TECHNIC

ANY act of skill, as defined by Thorndike, is due to two factors—form and execution.

Technic is form plus execution. When a nurse masters form, she knows what to do. In execution, she knows how to put her knowledge into practice. In the classroom, for example, she learns by study and explanation what to do when giving a hypodermic injection. She sees the procedure demonstrated on the wards. She "knows everything about giving a hypodermic"—but this is not enough. In her practical work, she must show that she can "get the right connection."

The probationer goes through a preliminary course in nursing procedures before she is allowed to "try her hand on the patient." Through her own study and the explanations and demonstrations of her instructors, she comes to have the right ideas of nursing technic. In addition to the facts taught about sterilizing utensils, she is shown how to do it. She proceeds to give her own demonstration of the procedure. She goes through drills of handling make-believe patients. She is

taught nursing procedures by doing them. From her books alone she cannot learn technic. It is not enough for her to rattle off solution formulas. She must show some skill in making them. Experts at solution problems, may prove bunglers in making up. Her demonstrations must be satisfactory before she is sent forth to prove her nursing skill on the wards. However good her nursing form, she is clumsy at first in execution. She has to "stop to make sure." Is she holding the end of the bandage between the right fingers? Deliberation marks her movements in arranging trays. The patients are not so comfortable when she tries to lift them as when the older nurse does it. She finds that making up an ether-bed in the demonstration room is one thing—and accomplishing it in a busy ward quite another. Her hands will not always do what she wants them to do. Long, long practice is necessary in perfecting technic. Through repetition, her nursing touch instinctively adjusts itself. It is some time, however, before her movements take care of themselves, leaving her free to attend the particular needs of the situation as she should. If her nursing form is correct as it should be, she always knows the right way to do things. She makes no guesses. Her movements, though they may be awkward at first, are not confused. As she develops her technic, she gradually makes her movements without thinking. There is, finally, no conscious decision as to how she shall hold the

hypodermic needle, or how she shall insert it; how she shall stand in lifting a patient, and so on—all the movements connected with nursing practice become so familiar to her that her execution bears the finished stamp of experience.

In trying to acquire good nursing technic, the nurse will need to keep in mind several guiding points:

1. Good technic can never be established if the nurse in her practice does things in the best possible way, only *part* of the time. Such a routine of correct movement should be set up that the nurse takes no thought of whether she is doing her best—she can't help doing her best, since this is the only way in which she has learned to work. It is a fact that nurses who do not train themselves rigidly to correct technic at all times, including minutest details, often fail in emergencies. When such nurses wish most to do the right thing, their movements are confused, because they have two ways of doing things and in a crisis they cannot "collect themselves."

2. In perfecting her technic, the nurse should set up a *tempo* as rapid as is consistent with careful work. The nurse cannot perform her duties as she should in emergencies unless she trains herself to work quickly. It is possible to work quickly and well, if one does so habitually. If the nurse ordinarily goes about her duties, moving as slowly as possible, she can never accomplish much when she must do an extra amount of work in a short

time, or when she is called upon to help in an emergency. She gets "flustered" when she moves with unaccustomed rapidity, and finds it impossible to do things as well as when she moves slowly. The matter of an even rapid tempo is highly important to the nurse's general success.

3. All useless movements should be eliminated. The nurse has only to watch other nurses at work to see how many superfluous movements are made in nursing procedures. Much time is wasted and energy as well, simply because nurses do not take the trouble, in their execution, to make as few movements as possible. The nurse may profit by reading Elizabeth Jordan's story, "Motion Study at St. Catherine's" (Harper's Magazine, April, 1912). The story calls attention in a humorous way to the possibilities of wasted movement. There is no reason why one should not learn something by way of a funny story as well as by lectures. After reading this story, it is probable that the nurse will make fewer dabs at her patient, that she will waste less effort "getting around." She will find it possible to make one movement do for two. The procedure in hand is executed better when the time is not taken up by useless movements. If the nurse knows what she wants to do, and plans ahead in detail, there is no need to make unnecessary work by unessential action. For the patient's sake nursing procedures should never be prolonged a second longer than necessary. The patient is often tired out by the "fussing

about" the nurse finds necessary before she can accomplish things.

Long, long ago dispatch was accounted necessary in good nursing technic. Among the many significant allusions in history, we find the following in Grecian records:

Concerning the bath Hippocrates says, " . . . Plenty of water of various temperatures should be in readiness for the douche, and the affusions quickly made . . ."[1]

His description of bandaging sets forth a fine technic:

"There are two views of bandaging, that which regards it while doing and that which regards it when done. It should be done quickly . . . by dispatching the work; without pain, by being readily done; with ease, by being prepared for everything; and with elegance so that it may be agreeable to the sight. . . . When done it should fit well and neatly. . . ."[2]

4. Deftness and sureness must go with quickness. In learning to do things quickly there is always the danger of a certain jerkiness that is very uncomfortable for the patient. Moreover, the nurse may go too rapidly to be absolutely certain of results. The tempo should be increased gradually, so that the nurse manages to do things with the same deftness and sureness as when her movements were slower.

[1] The Genuine works of Hippocrates, vol. ii., p. 252.
[2] *Ibid*, vol. ii., p. 10.

5. The nurse can never work to the best advantage, if she is "on a tension." It seems to be the popular idea that when one has to do things quickly, there must be an accompanying strain. In learning to work rapidly, the nurse should preserve absolute relaxation. She can work quickly without the least strain, if she will train herself to do so. As soon as she feels the least tenseness, let her pause and relax, resuming gradually the tempo desired—this time without strain. One thing that tends to bring about a tension is worrying too much over the result desired. Do the thing step by step, as it should be done, not letting the mind run on about "how it is going to come out." Poise and confidence added to deft quickness adds to the nurse's efficiency a hundred-fold.

Undesirable tension often shows itself when the nurse starts to lift a patient. Before she takes hold, her muscles are all on a strain, her body braced, as if already the weight were there. How different the easy movement of the nurse who, in lifting the patient assumes the proper position, muscles wholly relaxed, until the moment their power is needed!

6. Absolute control of the muscles is necessary in acquiring nursing technic. The nurse must control the instinct to start at sudden or unusual noises, or at the unexpected entrance of someone. If engaged in a nursing procedure, there should be no change of movement "under fire," or other trying circumstances. Nurses who have trained

themselves to such control, prove the most satisfactory not only in emergency work, but in the sort of nursing which is a test of endurance.

Exercises that will develop strength and control, as well as lightness of movement, should be a part of the nurse's regular training. She should study her hands particularly. If she has naturally the supple strong hand so much needed by the nurse, she starts at an advantage. However, much training is needed before her hands will be entirely equal to the highest performance of nursing procedures. The nurse, not less than the pianist, needs finger, wrist, and arm exercises. Not only her hands and arms, but her whole body, must be thorougly trained. The muscles should be made efficient in a great variety of movements, including arrested action. Even though compelled to stop in the middle of a rapid swing, the nurse should be able to do so without losing control of her muscles in the slightest.

Unless the body is moving in harmony with the laws governing perfect bodily control, the nurse can never achieve good technic. With her body *out* of harmony with these indispensable laws, she adds immeasurably to the fatigue of nursing. Lifting, such as the nurse may be called upon to do, need never tax her strength if she learns *how* to lift. Only by intelligent self-criticism and self-discipline may the nurse become master of her body. She may be aided by adequate instruction, but mechanical following of regulations, doing

specified exercises, will never work the desired result. Achieving bodily control is something the nurse must do for herself. Let the nurse criticize herself mercilessly. Does she use habitually in her work an arm motion bringing into play the large muscles of the shoulders and the upper back, or does she do things mostly with a forearm or upper arm movement? Does she reach for things without strain? Does she know how to elongate her body without feeling a tension? Does she distribute the burden of physical work so that all the strain does not fall upon a few muscles? Has she ever thought rhythm into her movements? The list of questions for self-analysis is not a short one.

7. Good technic is achieved by exquisite and infinite care. Without it, the nurse can never make caring for the sick, as it should be, "one of the fine arts."

# APPENDIX

## Directions for Making the Occupational Therapy Scrap-book

Articles necessary:

1. Cover material—a good strong quality of Manila paper or heavier cover paper in grey.
2. Paper for fly leaf—"onion skin" or fine typewriting paper.
3. Large needles.
4. Strong white or linen coloured thread, 30 inches to a book.
5. Paste—smooth, good quality.
6. Clips.
7. "Filler."

To make "filler":

1. Unbind magazines, leaving right and left margins full width. Leaves must not be torn loose.

2. Select the stories, pictures, articles, jokes, poetry, etc., desired. Use about 24 sheets or leaves to scrap-book.

3. If necessary, mount pictures, or short selections such as jokes or bits of poetry, upon maga-

zine leaves which you do not wish to use otherwise. Advertising sections may be utilized in this way.

4. Sort material so that each book has a motif —for example:

"Let's Go A-Journeying"—book of travel pictures.

"Here's Treasure for You"—book of verse.

"Once Upon A Time"—book of stories.

5. If pictures have advertising on one side, paste two good pictures back to back. Cover all print not included in your selections with pictures or other suitable material cut to fit. Often a story starts half way the page. The material above should be carefully obliterated by pasting over it something that fits in with your motif. If bits of unrelated printed matter are left here and there, the book has an unfinished look. Moreover, any unrelated material detracts from the patient's interest.

6. Place two flyleaves, 10 by 8½, corners together. Double over one inch at the back. Clip the "filler" to inner fold of cover. See that all leaves are absolutely even at the back. If you use a larger filler of course the flyleaf will have to be correspondingly larger.

7. Sew through inner fold of cover and all the leaves with four long stitches. Begin and end in the middle, taking first stitch from back to front. One half inch from all edges is left for margin in sewing. The ends of the thread should be at the back.

It is convenient to punch or bore holes for sewing before using needle and thread. Several clips may be used to hold the leaves firmly together while the punching is done.

Put the knot three inches from end of thread so that the ends may be tied. The long ends pasted down help to hold the back firm.

8. Paste flap of fly leaf back over stitches and down over the inner fold of the cover. Paste inner fold to back. Use little paste, but distribute it evenly. Close the book. Press.

9. Letter when paste is dry, with a suggestive "catchy" title, to stimulate interest and indicate the contents of the book. Attractive coloured pictures may be used on the outside of the book. India ink should be used for the lettering.

In making picture books, always choose a coloured picture for the first page. The interest is sustained by using coloured pictures at intervals. Something novel should be used first in order to catch the patient's attention.

The following list of books is representative of those made by The Stanford School of Nurses and used in Lane and Stanford Hospitals:

### While Away Books

1. *Folks.*—Containing pictures of all kinds of people, mostly unusual types. Adapted for use when a patient needs to have his mind taken away from himself. A book to awaken a morbid, self-centred patient to an interest in other people.

2. *Our Feathered Friends.*—A book about birds with coloured plates and detailed descriptions. A book for nature lovers. To be selected also when a patient needs to be awakened to a new interest or to develop concentration by studying detail. When the object is to develop concentration by studying detail. When the object is to develop concentration in the patient, an entertaining new study is best. The study of birds calls for attention to detail such as noting different colours, markings, etc. If the patient is strong enough, glasses may be used occasionally to study living specimens out-of-doors.

3. *Posies.*—Another book with coloured pictures and descriptions. State flowers designated. To be used in the same way as *Our Feathered Friends.* May be followed by making a collection of specimens. In the spring, a patient's friends will bring wild flowers for such a book.

4. *Do You Like Dogs?*—Pictures of dogs of all kinds, including war dogs that saw special service. A book for dog lovers particularly. Many pictures of puppies and trained dogs. "Movie" dog stars.

5. *Faces.*—Pictures of all sorts of faces—of animals as well as people. The pictures of human faces are those that tell interesting stories. A book to entertain.

6. *Faces and Places.*—A book of distant uneveryday places, with pictures of the people who live in these places. A book to carry a patient's mind away from the four walls of his sick-room.

7. *Fairy Trails.*—Pictures of fanciful poetical nature—useful in stimulating the imagination of the patient, or for entertaining one who loves uneveryday things.

### Story Books

8. *"Once Upon a Time."*—Selected stories of lighter type. Purely for entertainment.

9. *"And So It Was."*—Stories with a human appeal. Character studies. To be used when certain impressions or ideas are desirable as replacement wedges.

### Poetry

10. *Aboard the Ship O' Dreams.*—A book of short bits of poetry with an appeal to the simple, gentle emotions. Verses with rhyme interspersed with those that are merely rhythmic.

11. *Here's Treasure for You.*—Poems by well-known poets that have become popular. Also recently published verses by well-loved poets.

### Articles

12. What Do *You* Think About It? A stimulating book of short articles on various subjects of the day. Short direct articles which do not involve great concentration.

### Joke Books

13. *A Little Nonsense.*—A combination of jokes and cartoons about things which interest everybody.

14. *Kewpies.*—A book for diverting grown-ups or children.

### Essays

15. *Other People's Ideas.*—Essays and sketches such as may be found in "The Lion's Mouth," *Harper's Magazine*, The *Atlantic Monthly*, etc.

This will indicate somewhat the very wide scope of such books. The nurse's originality may have free play.

### The Nurse's Health

The nurse must constantly take into account the effect of her body upon her mind and the effect of her mind upon her body. Her general health must include a healthy mind as well as body.

Particularly important to the nurse is the recognition of the effect of the menstrual function upon her sensibilities. Not only during the period itself, but for several days preceding, marked effects may be noted. If the nurse will think of her emotions at this time as the result of her physical condition she will find it much easier to maintain the desired poise.

The effects of the monthly period vary according to the temperament of the woman, but the nurse will note quickly in studying herself, the particular effects she herself experiences. Before

the period—sometimes for as long as a week, but usually three days—many women experience a highly keyed condition. They feel as if they must be doing something constantly; they are "on edge," supersensitive to trifles; their efforts show lack of concentration; or, they may feel a decided desire for a change. Other women feel a general mental dulness and heaviness before the period. Their interest in things is lessened. They accomplish things with effort. This type usually feels a desire for extra sleep and succumbs readily to such inclination. There is a general "let down" in the general tone. . . . The woman of nervous temperament needs particularly to keep a grip upon herself at this time. She is inclined to show her nervousness in her bodily movements—starting at the slightest provocation, jerking at things impatiently, drumming with her fingers or keeping them active in some fashion, fidgeting about if she has to wait for something. She often shows lack of facial control. She may be moved to tears very readily. If she once gives way to emotion, she finds it hard to control herself. She is frightened at little things. If sanguine by nature she shows an abnormal response to suggestions, particularly for pleasure. Her laughter and her tears come readily if she is seeing a play or reading a sentimental story. Her sympathies are easily aroused. She is affected unduly by the dramatic aspects of life. She is excited "over nothing." If she is naturally imaginative, she finds her imagi-

nation "running away with her." She must keep a check upon it, in order that her action may not be influenced unduly thereby. The woman with a tendency to the choleric temperament goes about with a chip upon her shoulder and shows fits of temper over things of no importance. She is inclined to find more fault than usual. If nothing is wrong, she will find something. She seems determined not to be pleased. She may have many a painful "scene" which she bitterly regrets afterward. She is unreasonable and hasty in her judgments. In short she is not an easy person to get along with at this time. The woman tending to melancholy, shows unusual brooding and moodiness. She is prone to withdraw from everyone and mope. She quivers with tears of self-pity. She cannot be lifted from her despondency. Nothing seems worth while—the good things of life are not for her! The phlegmatic type is least affected, mentally. She may feel sluggish in both mind and body, but she does not show marked alterations in her usual behaviour. She maintains her cheerfulness without an effort. If she is slower than usual, she appears no less willing in her effort.

Most women, regardless of temperament, show less emotional control preceding and during the period. The nurse should make it a rule to write no important letters at this time if it can possibly be avoided, to make no important decisions; to refrain from expressing judgment upon any new subject, to obviate starting a new venture. In

controlling her emotions, if aroused, she will resort to change of bodily position, deep breathing or the simple diversion of drinking a glass of water. Most important in gaining self control, is *keeping before her mind that her emotional upheaval is only an indication of her physical condition.* There is really small excuse for the emotional outbursts, eruptions which occur at such times. Women ought to be ashamed of giving way to what is merely a physical thing. It is absurd to label the emotion as important, for nine times out of ten it is not, and would not seem so a week hence to the woman herself. To "take her feelings out" upon those around shows a deplorable lack of fineness.

Emotional feelings sometimes disappear at the beginning of the period, particularly if the functioning is without pain. There is less tenseness than preceding the period.

An understanding of this effect upon the emotions will help the nurse, not only in her own control, but in dealing with others. Her women patients must be particularly considered at such a time. Often in trying situations, her knowledge of another woman's physical condition will help her to be forbearing and not lay too much stress upon whatever may occur. Every fine-minded woman will feel the need of common-sense as well as delicacy in considering this part of her physical life.

Much may be done in caring for the physical

self to ward off the tendency to emotional outbursts and other effects. It is a fact that women commonly disregard the importance of special care directly preceding the period. For several days preceding, when the general resistance is apt to be lower, it is important to secure more rest than usual, to be more in the fresh air, to keep the eliminations of the body free, to eat with discretion, to avoid, if possible, undue strain, to refrain from much reading at night, to take milder forms of exercise, to keep warm and dry. These simple suggestions are all too often disregarded. Every woman feels better if she takes a lighter diet at this time. Concerning the matter of bathing, it is apparent that the old prejudice against it during the menstrual period still survives, despite the assertions of medical authorities that no harm can result if the bath is taken under the right conditions. Since the reaction of the body is not so good as usual, water neither too hot nor too cold is safe for the morning tubbing or spray. Prolonged baths are particularly unwise at this time.

. . .

So definitely defined are the effects of woman's physical life upon her general responses, that intelligent self-criticism is impossible without the inclusion of this subject.

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